Mr A Agarwal

Leiston Old Abbey Residential Home

Inspection report

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Ratings

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

Overall summary

Leiston Old Abbey provides accommodation and personal care for up to 40 older people, some living with dementia.

There were 15 people living in the service when we inspected on 29 September 2015. This was an unannounced inspection.

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.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Summary of findings

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

There was not 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 responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager working in the service who said that they would make a registered manager application with us when the provider advises them to do so.

Improvements were needed in how the service protects people in relation to medicines management and administration. The arrangements for giving people their medicines covertly were not in accordance with the Mental Capacity Act 2005.

There were not enough staff numbers in the service to meet people's needs safely and effectively. Appropriate recruitment checks on staff were carried out. Staff received training to meet people's needs. However, improvements were needed to ensure the quality, and range of training covered supported safe, personalised care.

Improvements were needed in the way that the service assessed and monitored people's safety in the environment. The premises were not well maintained and safe. Improvements were needed to ensure people were provided with a clean and hygienic environment.

Improvements were needed in how people's ability to make decisions were assessed and recorded. The manager had taken action to seek support in the recent changes to the law regarding the Deprivation of Liberty Safeguards (DoLS) but was not clear on the whole process.

People were not always supported to ensure that they had enough food and fluid to support their health needs. Records were incomplete and not assessed to make sure that people had received or supported with enough to eat and drink.

People were supported to see, when needed, health and social care professionals.

Changes in people's care was not always reflected in their records. This meant there was a risk to people receiving inconsistent care.

Staff had good relationships with people who used the service and spoke about them in a caring and compassionate manner. However, because improvements were needed in staffing levels, skills and knowledge in supporting people with dementia, people were not always provided with meaningful and caring interactions which they needed to reduce the risks of social isolation.

There service's quality assurance system was not robust. It failed to independently identify shortfalls in the care provided to people. Complaints and outcomes from safeguarding investigations had not been used to improve the service overall. There was no clear record or policy with regards to responsibilities and ownership for driving improvement in the service. The manager did not have a job description and had inconsistent supervision and support.

We found multiple breaches of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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 environment was not clean or safe. Improvements were needed to ensure any risks to people safety and welfare were identified and acted on.

There were not sufficient numbers of staff to meet people's needs safely.

Medication was not being managed safely. People were not provided with their medicines as prescribed which may put people's health and welfare at risk.

Is the service effective?

Inadequate

The service was not effective.

Staff were not effectively trained to meet the range of people's needs who used the service. This impacted on the quality of care they received.

Improvements were needed in how the service ensured people's legal rights were protected.

People were not always supported to have sufficient fluids and foods. Records used to assess if people had enough to eat and drink were incomplete and not robust.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff interacted with people in a caring manner. However improvements were needed in how they interacted with people living with dementia to ensure they received the same level of compassion.

People's privacy and dignity was not always promoted and respected.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's wellbeing was assessed, planned and delivered to meet people's needs. However, improvements were needed in how plans were documented and the language used.

Improvements were on-going with regards to people's social inclusion.

Complaints were not always acted on. Where people's concerns had been investigated and responded, they were not used to improve the quality of the service.

Is the service well-led?

Inadequate

The service was not well-led.

Summary of findings

Quality assurance and leadership within the service was not robust enough to independently pick up shortfalls and act on them. Feedback was not used to improve the service.

The service was not being run in line with it's own aims and objectives.

Leiston Old Abbey Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 September 2015, was unannounced and was undertaken by three inspectors including a pharmacist inspector. There was also an expert by experience who had experience of supporting a relative living with dementia.

We looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public. We had asked the provider to send us a provider information return (PIR) but this had not been returned when we had asked for it. The PIR asks the provider to identify the areas that they do well and the areas in which they need to improve.

We spoke with eight people who used the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection. We undertook as short observational framework inspection (SOFI) to observe people's wellbeing for those who may not be able to verbally share their experiences of the service.

We looked at records in relation to four people's care. We spoke with five members of care staff, including the manager. We looked at records relating to the management of the service, staff recruitment and training and systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Improvements were needed to ensure the premises and equipment provided was clean, maintained, safe and fit for purpose. For example where people's wardrobes were unstable, people were at potential risk from it being pulled or falling on top of them. No action had been taken to address this risk. Cupboard doors in the kitchen and ironing room, fell on us when we tried to open it. There were no signs to alert staff to the hazard. A strip light was not working so staff had improvised and plugged in a table lamp. The lamp had been placed under a wall cupboard used for storage. When we touched the cupboard it was very hot creating hazard which we asked staff to remove.

The lack of signage around the service did not support independence, or people's safety. People's needs varied but included those living with dementia and other conditions which may mean they would not always know how to recognise danger or know how to keep themselves safe. Staff confirmed people liked to walk around the service and were unrestricted. There were many areas were there were potential hazards including a carpet that was threadbare and causing a possible trip hazard, lights not working and where unlocked and unused bedrooms were used to store equipment.

People were not provided with a clean and hygienic environment. There were potential breeding grounds for germs because they were not being effectively cleaned. This included lime scale build up on taps and toilet bowls, dirty pull chords, sinks with dirty plug holes and overflow and discoloured and strong smelling plastic urinals pots. People's arm chairs, carpets and flooring was not being monitored effectively to ensure they wee being kept clean to prevent staining and odour.

The systems in place to deal with 'Cluster flies' were not effective enough to prevent or reduce the risk of impact on people's health and welfare. We saw flies landing on a person's open wound and were so concerned we brought it to the staff's attention. They arranged for the person to be seen by a health professional who dressed the wound.

Improvements were required in the management of medicines. People told us that their medicines were given to them on time. One person told us, "I have tablets at tea time, seven days a week and have never missed them." However records showed that people were not always provided with their medicines as prescribed which may put people's health and welfare at risk. When we compared the records against quantities of medicines available we found discrepancies and gaps. For example some medicines remained in their containers but the corresponding records showed they had been administered. The manager was unable to explain the discrepancies and they had not been picked up by the services own audit.

One person had not received their prescribed food supplements because staff said they had run out. We saw that the stock had been available, but none of the staff supporting the person, had alerted senior staff to its location. This resulted in the person not receiving their nutritional supplement for three days.

When people were prescribed medicines on a 'when required' basis, there was a lack of written information available to show staff how and when to administer them. The manager was unable to demonstrate how staff ensured that this was monitored and recorded to ensure people had the medication when they needed it.

Staff authorised to handle and administer people's medicines had received training but had not been assessed to ensure that they were competent. As a result we were concerned that people may not have had their medicines administered by competent staff potentially increasing the risk of error.

There were also discrepancies for controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) including both the inappropriate completion and deletion of records by staff. The manager was unable to locate missing controlled drugs but felt that they had been returned to the chemist. Following the inspection they notified us that they had reported the matter to the police who were investigating. The records they provided showed that 'various' unnamed medicines had been returned. This did not give a clear audit trail and raised concerns that the service did not have robust systems in place to ensure people's medicines were ordered, stored and disposed of safely.

Improvements were needed to ensure all risks associated with people's individual health needs had been identified and acted on. For example there was no risk assessment

Inadequate

Is the service safe?

associated with indwelling catheters to ensure staff took appropriate action to prevent the risk of trauma and knew how to recognise associated infections or potential problems for those that used them.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations

The manager said that staffing levels had been decreased to reflect the lower number of people supported in the home. People told us that there were enough staff available to meet their needs, but at times may have to wait for assistance. One person told us, “It depends if they are busy, they come in the end when they are available.” Another person remarked, “They are looking after me in a fashion, I ring the bell and it takes quite a while, take 10 minutes and more.”

Staffing levels did not take into account the people’s dependency needs, skill mix and layout of the premises. Therefore the quality of care people received, was dependant on their location, whether it be in their bedroom or communal areas. Staff carried out checks on people in their private bedrooms as required by the care plan but these were quick with little interaction between the member of staff and the person. Staff did not have the time to give people the social interaction they needed, as they were required to immediately return to assist others in the communal lounge area. At tea time staff brought people a meal tray but did not go back to provide adequate support and encouragement, as described in their care plan. For example, a person who required encouragement still had untouched food in front of them three hours after the tray had been left.

In communal areas staff were not able to meet people’s needs. The senior carer was required to complete kitchen duties and the administration of medicines. This left two care staff, unable to support people to enjoy their meal, due to constantly being required to carry out other tasks. For example collecting items from the kitchen, answering call bells and the front door. When staff did not have a presence in the lounge, there was an impact on how people interacted with each other. For one person this was a negative experience because there were no staff to intervene and make sure people were safe and happy.

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

Staff had received training in supporting them to understand the policies and procedures relating to safeguarding and their responsibilities to ensure that people were protected from abuse. One staff member told us, “The residents are very safe.” They knew how to recognise indicators of abuse and how to report any concerns

Records showed that checks were made on new staff before they were allowed to work alone in the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service. One person told us, “I have got people to look after me, I feel safe.” Another spoke about their personal possessions being safe, “My things are in my room and I have never had anything taken.”

Inadequate

Is the service effective?

Our findings

Staff did not have the knowledge and skills they needed to carry out their roles and responsibilities and provide effective care. The service cared for a number of people living with dementia but staff did not understand how this impacted on individuals. Therefore they were unable to deliver effective and meaningful care. For example care records showed a person could be scared and anxious. However their it had been recorded that instead of being offered reassurance they were told by a staff member that their behaviour was, "completely unacceptable," and described as being "nasty," before refusing to support the person further, and walking out on them. This did not demonstrate any understanding or good practice.

Staff were not trained to provide effective catheter care and this meant they failed to recognise where they needed to take action to ensure a person's wellbeing. For example there were no checks in place to ensure a catheter bag was positioned correctly or that monitoring fluid levels took place to help prevent infections. We had to ask staff to reposition a person's catheter bag as it may have caused injury and discomfort.

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

People were not always supported or provided with sufficient amounts to eat and drink. A person's care plan stated that they had a poor appetite and needed encouragement to eat and drink. However, a recent complaint from a family member showed that they brought in food for the person as they did not like the food on offer in the service. This was not incorporated into the person's care plan to show how support was being provided to maintain a healthy diet.

Two people who chose to remain in their bedrooms were identified as having a 'body mass index' which classed them as underweight. Care records showed they were under the guidance of the dietician and required support and encouragement to eat their meals. Discussions with staff and our own observations showed that the guidance given by the dietician was not being followed. For example nourishing snacks between meals to increase calorific intake were not being offered. People at risk of malnutrition were not being encouraged to eat and drink by staff. For example we saw one person had a piece of cake laying on their bed table, alongside the three drinks they had accumulated during the day. The drinks had not been drunk and had not been removed. We were concerned that this did not alert staff to take further advice or action.

There were inconsistencies in records of food /fluid that people had which made it difficult for the home to demonstrate what people had eaten or drank. The manager told us that the staff were not completing records as directed. Some records showed nothing had been eaten, or little fluids taken for long periods. For example one person had been given a cup of tea at 9.55am, and the next recorded drink was 3.30pm. The manager told us there was no system in place to monitor a person's food and fluid intake each day to alert staff to any potential problem and ensure the advice given by the dietician was being carried out.

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

People told us that they were provided with choices of food and drink. One person commented that the, "Regular meals are quite satisfying and the board now shows todays menu and there are choices." Another person told us, "The food is not bad, quite good and I am quite happy with the food, you never go hungry here and you can have as much as you like."

People told us that the staff sought their consent and acted in accordance with their wishes. One person told us, "I get up at 7.30am, it is the time I like to get up and go to bed at 10.30pm." We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meals. For example, where a person looked liked they needed assistance, a member of staff approached and asked, "Would you like me to cut your meat up?" and acted on their reply.

Improvements were needed to ensure that the manager and staff understood their responsibilities with regards to Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA) within the care home setting. The DoLS consider that a person's rights are fully explored and any restrictions be placed on their freedom in order to keep them safe are lawful. A referral made by the service in this respect had been sent to the wrong agency showing a lack of understanding of the process and responsibilities in this area.

Inadequate

Is the service effective?

The service did not follow correct authorisation procedures when medicines were given to people without their knowing (covertly). Records showed that the service had consulted with their GPs, however, the manager confirmed there had been no assessment or recording of people's lack of capacity to consent to their medicines being administered in this way. There were no records showing best interest decisions had been made by the appropriate people on their behalf.

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

People said where they required the support of healthcare professionals, this was provided. This included visits from chiropodists and community nurses. Records showed that people were supported to have access to healthcare services and received on-going healthcare support.

Requires improvement

Is the service caring?

Our findings

Furnishings and fitting supplied by the service did not ensure people's privacy and dignity. For example, one person's bedroom had no door or privacy screen to their ensuite toilet. There was no lock on a shared toilet. Curtains in people's bedrooms did not fully cover their windows and continence aids were visible in bedrooms so they could be seen by their visitors. Although there was a program of refurbishment, priority had been given to a new conservatory and there was no analysis, consideration or plan with regards to environmental impacts on people's privacy and dignity. These issues had also not been identified by any monitoring completed by the manager or provider.

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The arrangements in place for the running of the service did not promote and encourage staff, through training, understanding of people's needs and day to day routines, to be caring. Although at times staff demonstrated they were intuitively caring, the services task based approach and lack of time meant this could be challenging . People told us that staff were caring and treated them with respect. One person told us, "Staff are quite respectful and they treat us kindly, I am amazed about how much patience they have." Another told us that staff were, "Nice, very nice… it is very pleasant here." Where a third person had mixed views, "Some I get on with and some I don't, but they do a good job…they are not unkind." Staff spoke about people in an affectionate and compassionate manner. One staff member told us that, "Best thing here is the people, the residents and staff get on."

Improvements were needed to ensure that the service focussed on ensuring people's overall wellbeing. Staff did not have the time to sit and have meaningful talks with people who remained in their bedrooms. One person who told us that, "Staff don't come and sit and chat to me; I have my family who visit me."

We observed staff giving choice by supporting people to express their views, and make decisions about their care. For example staff assisting a person asked, "We can either help you with the hoist and go to the dining room, or we can bring a small table and you can have lunch in here," allowing the person to decide. In the lounge, when a person asked staff to change the television channel. Staff checked with the other people first, "Do you mind if the channel is changed?" This showed that they were respectful of others.

Requires improvement

Is the service responsive?

Our findings

Care plans did not provide staff with information about how to meet people's needs. People's specific needs relating to their conditions were not detailed and did not identify how they affected their daily lives, warning signs for staff to be aware of and actions that staff should take to minimise risks. The manager told us about one person's complex needs but when we examined their care records this information was not detailed in them. It was not clear how staff had the information or what they referred to in order to provide appropriate and consistent care. At times records were contradictory, for example in one area of a person's care records it stated that the person should be asked if they had any sore areas on their skin, and in another part it told staff to check the person's skin on a daily basis. The manager told us that they had an arranged visit with the local authority quality team where they were going to look at how the care plans could be improved.

Allocation sheets completed on a daily basis, identified the support that each person needed, including how often they needed to have their continence pads changed.However records of when people had been supported with their continence care were incomplete and could not be relied upon to demonstrate care had been provided. For example one person's records showed no checks for over seven hours but when they were checked their pad had been wet. The person could have been in this situation for some time. Another person had not been checked for eight hours but their pad was dry. It was not clear if they had been supported to change and this was not recorded or if this was an indicator that there was another health care need, for example dehydration.This could result in people not receiving the care they required and could also increase the risks of pressure ulcers developing or discomfort.

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

People told us that they knew who to speak with if they needed to make a complaint and could speak with staff if they were concerned about anything. There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. However, this was not effective and was not used to drive improvement. For example some records of complaints showed that they were not responded to in appropriate timescales. One complaint had been received 2 May 2015 and a response was not sent until 30 July 2015. In one person's daily records it stated that they had complained that money was missing, this had not been recorded as a complaint or reported as a safeguarding concern and there were no outcomes recorded to show what action the service had taken. This did not demonstrate the manager and provider had looked at the concerns and taken appropriate action to limit their reoccurrence and improve the service overall.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that people were provided with the opportunity to watch visiting entertainment and go out in the community for lunch. One person told us about the quizzes arranged three times a week, "They are very good I am pleased with them." However records showed that there was limited opportunity for people to participate in activities that interested them. One person told us, "I try to avoid being drawn into things like bingo," but no alternative was offered. Another person told us how they were, "Not a competition," person, so avoided the bingo, and similar games. A staff member told us that they were given three hours, three times a week to support organised activities but had completed no specific training on how this should be developed within the service.

People told us that they could have visitors when they wanted them, which reduced the risks of them becoming isolated or lonely. One person told us about their weekly trips to their relative's house for, "Supper." Another person said they enjoyed going out with their relative to, "Do some shopping, meet friends and have lunch out."

Inadequate

Is the service well-led?

Our findings

Leadership within the service was inconsistent. In the last two years there had been four managers in post; The new manager who started in post 1 August 2015 in post told us that they had started a relevant management qualification. They had not yet applied to the CQC to register.

There was no information available to confirm who was responsible for ensuring oversight and monitoring of the quality at the service and there was no related policy and procedure. Roles and responsibilities within the service were not clear. The manager told us that they felt supported in their new role, had been provided with an induction by the previous manager and that the provider visited once a week where they discussed what needed to be done. However, when we asked to see their most recent supervision document it showed a list of tasks to complete and there was no information about how the provider had discussed how the manager was developing into their role or any issues they had or further development needs identified. We asked to see the manager's job description for their role but this had not yet been provided to them by the provider.

The quality of service people received was inconsistent. Some people were able to articulate their views were positive about the service received. However others who were not able to express their views and had more complex needs did not always experience care that was safe, effective and met their needs. The service was not providing a person-centred, open, inclusive and empowering culture. People were not actively encouraged to be involved in developing the service or provided with the opportunity to share their views. The manager told us that only two people had attended the last 'resident's meeting'. No action had been taken to explore why this was the case or look at ways in which to engage people more. A satisfaction survey had been sent out but the results of this had not been recorded or analysed. The opinions of people who were unable to voice their views, for example those living with advanced dementia were not sought or explored further to see if other methods could be used, such as advocates.

Quality surveys had been completed by staff but there their comments had not been explored, addressed and used to improve the service.

Feedback from professionals included concerns about lack of response to a complaint and examples where the provider had been slow or not responded to their requests for information. This did not assure them that the provider would ensure improvements were made that benefited people using the service without delay. Information from concerns raised about people's safety (safeguarding) and complaints were not being used to drive quality across the service. Where action was taken to implement new systems to address shortfalls we found that similar issues had re-occurred.

The provider had a 'Statement of Purpose' for the service dated December 2014. Seven of the nine aims and objectives included were not being met. For example one aim was to provide, 'a high standard of care as required by individual residents,' however concerns during the inspection for two people's welfare led us to instigate a community nurse to visit one, and make a safeguarding referral for the other. As a result the local safeguarding team put a 'protection plan' in place to ensure one person's safety and welfare. The manager told us that they had an arranged visit with the local authority quality team to support them to make improvements. However we are concerned about the provider's long term ability to ensure they have robust systems in place to independently recognise shortfalls and take action to embed and sustain improvements.

Audits did not identify shortfalls we picked up during the inspection in infection control. This raised concerns about the skills and knowledge of staff completing the audits. The provider had checked the audits but had not undertaken any further activity to ensure they were accurate. Environmental risk assessments and cleaning schedules had not been appropriately monitored to ensure that bedrooms were clean and hygienic and that the furniture and soft furnishings were fit for purpose.

A falls audit had recently been introduced. However, on examination of accident and daily care records these were not accurately recorded and were contradictory. For example the audit stated that one person had falls in August 2015, however, none of this information was recorded in their daily care records. Therefore the audits could not be used effectively to monitor falls, identify potential trends and actions staff and others should take to reduce the risks to people.

Inadequate

Is the service well-led?

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

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 10 HSCA (RA) Regulations 2014 Dignity and respect **People's privacy and dignity was not assured.** **Regulation 10 (1) (2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People's capacity to make decisions were not adequately identified and actions taken to ensure that decisions are made in their best interests.** **Regulation 11 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People are at risk of not being supported to eat and drink enough because their nutritional and hydration needs were not adequately assessed and met.** **Regulation 14 (1) (2) (a) (b) (4) (a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Records were incomplete and could not be relied upon to show that people had received their assessed care needs.** **Regulation 9(1)(b)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The complaints system was not effective. Reg 16 (2)

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.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were at risk because they were not provided with safe care and treatment. Regulation 12 (1) (2) (a) (b) (e) (f) (g) (h).

The enforcement action we took:
We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Systems or processes are not robust, established and operated effectively to ensure risks to people are mitigated and to provide a good quality service to people. Regulation 17 (1) (2) (a) (b) (e).

The enforcement action we took:
We have imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People are at risk because there are not sufficient numbers of suitably trained, competent, skilled and experienced persons deployed in the service to meet people's needs. Regulation 18 (1) (2) (a)

The enforcement action we took:
We have imposed conditions on the provider's registration