ADR Care Homes Limited

St Nicholas Care Home

Inspection report

1-3 St Nicholas Place
Sheringham
Norfolk
NR26 8LE

Tel: 01263823764
Website: www.adrcare.co.uk

Date of inspection visit:
26 November 2019

Date of publication:
30 January 2020

Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service: St Nicholas is a residential care home that was providing accommodation and personal care to 10 people aged 65 and over at the time of the inspection.

People's experience of using this service and what we found
At this inspection we found a continuation of failings at this service. Sufficient action had still not been taken to address the seven breaches of the regulations we found at our previous inspections in November 2018 and May 2019. At this inspection in November 2019, we found an additional breach of the regulations.

This will be the third consecutive inspection that this service will be rated as inadequate overall.

The provider had not ensured the manager for the service had registered with us as is required and there continued to be a lack of oversight of the service from the provider. Governance systems remained ineffective at identifying shortfalls within the service and improvements noted by relatives had not been actioned.

Risks relating to people's health and wellbeing had not always been identified or plans put in place to mitigate these risks. People were not supported to maintain an adequate intake of food and fluid.

Staff practice relating to infection control remained poor and there continued to be several environmental risks identified in the home that had not been managed well.

Reviews of accidents and incidents remained poor and investigations to learn lessons from incidents did not take place. The provider continued not to report notifiable incidents.

We found an additional breach of the regulations. This was because the provider failed to report a safeguarding incident to the local authority and thoroughly investigate the concerns.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People continued to receive care that did not always uphold their dignity or respect their privacy.

Records of people's care still lacked person-centred detail and were not reflective of people's most current needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)

The rating for this service was inadequate (published 26 July 2019) and there were multiple breaches of regulation. At this inspection we found sufficient improvements had not been made, and the provider remained in breach of seven regulations. We also found one new breach relating to safeguarding people from abuse and improper treatment.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 14 May 2019. Breaches of legal requirements were found in relation to safe care and treatment, good governance, meeting nutritional and hydration needs, need for consent, person-centred care, dignity and respect and notification of other incidents.

We undertook this focused inspection to check the provider had now met the legal requirements. This report only covers our findings in relation to the key lines of enquiry which relate to those requirements.

The ratings from the previous comprehensive inspection for those key lines of enquiry not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service is inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Nicholas Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, good governance, need for consent, person-centred care, dignity and respect, meeting nutritional and hydration needs, safeguarding people from abuse and notification of other incidents.

CQC used its powers to keep people safe, and a Notice of Proposal to vary a condition on the Registered Provider's registration, to prevent the regulated activity being carried on at St Nicholas Care Home, was sent to the Registered Provider on 18 January 2019. On 26 March 2019 the Notice of Decision was sent to the Registered Provider advising that we had decided to adopt the proposal to vary a condition on their registration.

The Registered Provider appealed against this decision to the First Tier Tribunal (Care Standards) under section 32 (1)(b) of the Health and Social Care Act 2008. The appeal hearing was held on 9, 10, 11, 12 and 13 December 2019, and the decision was made that CQC's action "was both necessary and proportionate." The appeal was dismissed by the tribunal judge and CQC was informed of this decision on 22 January 2020. This means that the Registered Provider can no longer provide any regulated activities at St Nicholas Care Home and the service is now closed.

Following the Tribunals decision, the local authority took swift action to ensure that all people living in the service were supported to move to alternative accommodation. The last person moved out on 24 January 2020.

This service is therefore no longer in operation.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

St Nicholas Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
St Nicholas is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a manager who had been in post since February 2019, but they were not registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information that we held about the service and registered provider. This included any notifications and safeguarding information that the service had told us about. Statutory notifications are information that the service is legally required to tell us about and include significant events such as accidents, injuries and safeguarding notifications. We also contacted the local authority and safeguarding team for feedback about the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

We used all this information to plan our inspection.

During the inspection-
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with three members of staff including the manager, a member of care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at three people's medicines records. We also looked at one staff recruitment file and related supervision records. We reviewed a range of documents relating to the day to day running of the service, these included manager and provider reports. Observations were made of the care and treatment people received throughout the inspection. We requested copies of people's care records to review after the inspection.

After the inspection
We reviewed three people's care records in detail. We requested copies of documents we had not been provided with when we had originally requested them during the inspection. We followed up a safeguarding referral we had asked the manager and nominated individual to make.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong; Preventing and controlling infection

At our last inspection the provider had failed to ensure that risks to people and within the environment were mitigated. They also failed to ensure accidents and incidents were recorded thoroughly and investigated and infection control procedures were effective. These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Known risks to people's safety were not always planned for or mitigated. One person's care record stated they had lost weight, there was no risk assessment in place relating to their recent weight loss.
● We saw from the same person's care records they could show behaviour that challenged and behave aggressively towards other people. There was no risk assessment to detail how this risk could be mitigated to keep the person, other people and staff safe.
● Risk assessments for people's moving and handling needs were not completed correctly, therefore we could not be assured every measure had been put in place to mitigate this risk. For example, one person's moving and handling assessment stated on the first page they were not resistant to using the hoist. The risk assessment then stated twice the person did not like to use the hoist. A second person's moving and handling risk assessment had not been completed. Therefore, staff did not have sufficient information to understand how to support these people to move safely.
● People were at risk of accessing potentially hazardous areas of the home. The whole of the first floor was unoccupied but could be accessed via a lift. There was an alarm on the lift door to alert staff should people try to use the lift, however, the alarm was not switched on.
● A risk assessment for some planned works was not completed. It was not clear what the level of risk was to people who used the service.
● A fire risk assessment showed that deficiencies in relation to fire safety identified in May 2019 had not been completed, which placed people safety at risk.
● We reviewed three people's medicines records against the balances of people's medicines available to ensure the amount of medicines in stock tallied with the administration records. We found one tablet was missing for one person. The manager was unable to tell us what had happened to the tablet. Therefore, they could not be assured the person had received their medicines correctly.
● Analysis of accidents and incidents was not robust, and accidents and incidents were not always recorded or reported to other agencies when required.

● One person had sustained a skin tear. No further investigations had taken place to try to ascertain how this had happened. We saw from a weekly manager's report that one person had tried to take tablets which had not been prescribed for them. There was no incident form for this and therefore no investigation into this potential risk.
● Our review of the weekly manager reports showed that one member of staff had been caught sleeping whilst on night duty and dismissed. No incident report had been completed and no investigation had taken place to ascertain if the people living in the service had potentially come to any harm because of this.
● Our observations showed the kitchen to be unclean. We noted there was a pile of mugs and dishes by the side of the sink which looked unclean. The manager told us they had been cleaned. We also observed there was food debris in the fridge.
● A review of the kitchen cleaning schedules showed the inside if the fridge was not consistently cleaned. It had not been cleaned for four consecutive days during the week prior to our inspection.
● We observed care staff in the kitchen did not always wear the correct personal protective equipment such as disposable aprons. We also saw one member of staff leaning across an island in the kitchen and the front of their uniform was in contact with the surface. This posed a risk of cross-contamination.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● We saw from the weekly manager reports that concerns had been identified in relation to inappropriate conduct by a member of staff towards other members of staff. No further investigation took place to ascertain if people living in the service had also been affected.
●The manager confirmed the concerns had not been reported to the local safeguarding team, therefore, the provider failed to ensure people were protected from the risk of abuse.

We could not be assured the safeguarding concerns had been appropriately reported and investigated, therefore, placing people at risk of harm. These new findings constitute a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment
● We checked one staff recruitment file in relation to the safeguarding concerns we found. Pre-employment checks had been carried out as is required with the Disclosure and Barring Service and references sought. Therefore, these completed as is required.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection we found the provider had failed to ensure consent to care and treatment was provided in line with law and guidance. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 11.

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.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Assessments of people's capacity to make decisions about their care and treatment were not decision specific. These assessments also contained inconsistent information and did not reflect why people were being deprived of their liberty or what decisions staff were required to make in people's best interests.
- One person's mental capacity for personal care stated they needed support with personal care but failed to detail this person could attend to their own oral hygiene and take themselves to the toilet, as described elsewhere in their care records. This assessment of capacity regarding personal care was not decision specific and did not promote the person's independence.
- A second mental capacity assessment for consent for this person detailed they could not make complex decisions but could consent to services provided by the chiropodist and hairdresser. This assessment was

not decision specific and implied this person could only make decisions about seeing the chiropodist or hairdresser.
● A second person's capacity assessment for personal care did not specify what care was being provided in the person's best interests as it stated they were sometimes independent with their personal care and required prompting at other times. This assessment also failed to detail why staff were required to make decisions in the person's best interest regarding their personal care.
● The mental capacity assessments detailed that the decisions being made in people's best interests were applicable to the applications made to deprive them of their liberty. However, it was not clear how people were being restricted in relation to decisions being made in their best interests.
● CCTV was in use in the communal areas of the home. The manager and nominated individual were unable to say if this recorded sound and how long people's data was stored for. There was one sign in the home to show that CCTV was in use. This was in the main entrance which was not frequented by people who lived in the home.
● People or their relatives had not been consulted about the use of CCTV and what the purpose of it was. One person and their relative we spoke with confirmed this.

These findings constituted a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had failed to ensure people's nutritional and hydration needs were being met. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 14.

● We were informed by the manager each person's food and fluid intake was recorded throughout the day. We reviewed people's care records in relation to this and remain concerned that risks relating to people's nutritional and hydration were not adequately managed or monitored.
● One person had recently lost weight which necessitated a referral to the dietician. There was no care plan or risk assessment in place. The Malnutritional Screening Tool (MUST) had not been completed for this person. MUST is a five-step calculator for determining nutritional risk. It also provides guidelines about how to support a person who is at risk of malnutrition. The lack of adequate risk assessment was of concern as this person was living with diabetes and a pressure ulcer risk assessment in their care records showed they were at very high risk of developing a pressure ulcer.
● This person's nutrition and hydration care plan stated they should have fortified food. We observed this person eating their evening meal and the food was not fortified and the list in the kitchen of people's dietary requirements did now show this person required a fortified diet.
● This person was also at risk of choking as they had not been given a meal prepared according to their needs. This person was unable to chew their food properly and they had been given boiled potatoes with the skin on. We also noted they had difficulty cutting their food and had to lean to the side to access the poorly placed table.
● The amount of food and fluid people consumed each day was not recorded in detail. For example, we saw that one person had an evening meal, but it did not stipulate what the meal consisted of and how much the person had consumed.
● A second person's care plan stated they should be encouraged to drink plenty of fluid. Their care records failed to consistently document how much fluid they consumed. Therefore, the manager was not able to

monitor if they were receiving sufficient amounts to meet their needs.

These findings constituted a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● After our inspection in November 2018, we placed a condition on the provider's registration which meant they were not permitted to admit people to the service.

Staff support: induction, training, skills and experience
● Staff support was not reviewed during this inspection.

Staff working with other agencies to provide consistent, effective, timely care
● Staff working with other agencies was not reviewed during this inspection.

Adapting service, design, decoration to meet people's needs
● The adaptation of service design and decoration was not reviewed during this inspection.

Supporting people to live healthier lives, access healthcare services and support
● Supporting people to live healthier lives and access to healthcare services was not looked at during this inspection.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our last inspection we found the provider had failed to promote people's privacy and ensure that people were cared for in a way which upheld their dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 10.

● People's privacy was not always respected. We saw one member of staff enter two people's rooms without gaining permission. They walked into one person's room twice, one of those times their door was shut. This could have compromised the person's dignity had they have been receiving personal care at the time.
● Whilst we were outside, we observed one person being hoisted in the front lounge. It was dark at the time and members of the public would have been able to see this as the curtains had not been drawn. At lunchtime, we saw a domestic cleaning one person's rooms whilst the person was sat in bed eating their lunch.
● The use of CCTV in communal areas meant people were being filmed whilst receiving care and treatment without their consent. The use of CCTV also meant people were being filmed whilst spending time with their visitors.
● Personal information about people was not always kept in a safe and confidential way. There was personal information about people kept in the manager's office, but this was not always kept locked when unoccupied.

These findings constituted a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Ensuring people are well treated and supported; respecting equality and diversity
● During our inspection we observed staff missed opportunities to engage with people. For example, we observed one staff member to be sat in the lounge on their personal phone whilst there were three people sat in the lounge.
● We did see some caring interactions between staff and the people they were supporting. For example, we saw one member of staff gently encourage one person to mobilise through the home.

Supporting people to express their views and be involved in making decisions about their care

● People's relatives we spoke with told us they had been involved in planning people's care. One person's relative described how staff showed them their family member's care plan.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them;

At our last inspection we found the provider failed to ensure people's care was personalised to meet their needs, preferences and gave them choice and control. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9.

● People's care plans continued to lack personalised detail and did not document their most current care needs. For example, one person's recent assessment of their cognition stated they did not have dementia. We had been told they were living with dementia and this was referenced at other points in some of their care plans, but this was not referenced consistently throughout their entire care record.
●One person's care plan showed they could become confused and unsettled. There was no further detail to guide staff about what support the person needed under these circumstances.
● A second person's care plan showed they could become very upset at times. There was nothing in their care plan to detail what circumstances should be avoided to minimise the risk of this or what support they required when experiencing such intense emotions.
● One person's care record failed to consistently document their care needs in relation to their oral health. One document detailed that the person did not have any teeth and did not wear dentures. A second document we looked at detailed they had their natural teeth.
● There were no specific dementia care plans in place for people who were living with dementia.
● People's preferences were not met. One person's care plan stated they liked to have their breakfast in the dining room and remain there for the morning. On the day of our inspection we saw them having breakfast in the lounge. Their daily care notes showed they were often served their breakfast in their room.
● Daily notes of people's care had not improved and were still brief and did not link to people's care-planned needs. This meant there was no record on an ongoing assessment of people's health and wellbeing. There were still duplicate entries which made it difficult to have an accurate overview of the care people received.
● The daily notes remained task-focussed and consistently described people as being 'content'.
● There had been a decline in activity provision since our last inspection. One person's relative told us there were not many activities going on in the home. On the day of our inspection the manager told us there would be some activities, but we did not see anything being provided.

● We reviewed the weekly manager reports from August 2019, these showed there was the provision to provide 25 hours of activities a week. These reports showed none of the budget available had been used to provide activities within the home.
● People's food and fluid intake was monitored regardless of whether they required this level of observation.

These findings constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The AIS was not met and we did not see that people were given information in an accessible format. For example, there were no pictures to accompany the menu.
● Whilst people had communication plans in place, these did not detail how picture cards or other alternative formats could be used to maximise people's understanding of their care and treatment and day to day decisions.

End of life care and support
● People's end of life care plans lacked detail. There was nothing to detail what people would like in their final days, for example, if there were any personal effects they wanted near them or if they would like a book read to them, or music played. The was also little information about people's funeral arrangements.

Improving care quality in response to complaints or concerns
● No complaints had been received since our last inspection. The provider had a system in place to manage and investigate complaints if they arose.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection we found the provider had failed to make enough improvement to achieve compliance with the Regulations and implement robust governance systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

No improvement had been made at this inspection and the provider remains in breach of regulation 17.

- The provider has consistently failed to implement robust governance systems and has been in breach of this regulation since January 2017.
- The manager had been in post since February 2019. The provider had not ensured they had applied to become the registered manager as is required
- Effective systems to monitor and assess the safety and quality of the service were not in place. Whilst audits had been completed to assess and monitor the service, these did not identify the multiple shortfalls we found. For example, a provider report showed accidents and incidents had been reviewed but failed to identify a potential safeguarding concern.
- A second provider report also failed to comment on the safeguarding concerns relating to a member of staff's conduct. This report also noted there were no issues with medicines but a medicines audit from an external professional for the same month noted several issues.
- Reviews of people's care records failed to identify these contained incorrect and inconsistent information which increased the risk of people receiving unsafe and inaccurate care.
- People's relatives had been asked to complete a quality assurance questionnaire. We saw that one relative had made several comments relating to the quality of the service on their questionnaire. The results of the questionnaire did not document all of the comments made.

These findings constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection we found the provider had failed to report notifiable incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider continued to fail to report notifiable incidents. And was still in breach of regulation 18.

● As discussed in the 'safe' section of the report, a safeguarding incident had not been reported to safeguarding and we had not been notified of this incident. A second incident where a person had sustained a skin tear had not been reported to us and had not been identified as a potential safeguarding concern.

This finding constituted a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulation 2009.

Working in partnership with others
● Staff at the service worked with the local authority, district nurses and the local pharmacies.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not reported, without delay, potential safeguarding concerns to the local authority or CQC. Regulation 13 (1) (2)

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of reportable incidents. Regulation 18 (1) (2) (e)

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the care people received was appropriate, met their needs and reflected their preferences. Regulation 9 (1), (3) (a) (c) (d)

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with respect and have their dignity and privacy upheld. Regulation 10 (1) (2) (a) (b) (c)

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the mental capacity to

make a specific decision the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005.

Regulation 11 (1) (2) (3)

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure accurate and effective assessments of risks to the health and safety of people using the service. The provider had also failed to do all that is reasonably practicable to mitigate any such risks. The provider had failed to mitigate the risk of the spread of infection and ensure effective infection prevention and control. Regulation 12 (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutritional and hydration needs of people were consistently met. Regulation 14 (1) (2) (a) (b) (4) (a) (c) (d)

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records.

Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

Notice of Decision