Pinecourt Limited

Cross Way House Care Home

Inspection report

59 Crossway
Havant
Hampshire
PO9 1NG

Tel: 02392455056

Date of inspection visit:
05 May 2016
06 May 2016

Date of publication:
27 July 2016

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

This unannounced comprehensive inspection took place on 5 and 6 May 2016. Crossway House provides accommodation for up to 24 people. At the time of our inspection we were told there were 13 people living with a learning disability and nine people who were older and living with dementia. The age of people accommodated varied from 59 – 98. The registered manager referred to in this report no longer works at the home and has submitted an application to remove themselves from our registers as the registered manager. A new manager is in place, who has submitted an application with us to become the 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.

The last inspection took place in November 2013, which was to follow up a requirement made at the previous inspection in July 2013, which related to records. We found the necessary improvements had been made and the home was compliant in November 2013.

At this inspection, some staff understood the principle of keeping people safe, but we witnessed some situations where people were not safe. Staff also told us about previous incidents, where people and staff had not been safe.

Risk assessments had not always been completed to ensure staff were aware of people's risks and how to minimise the risks, to ensure people's safety.

Staffing levels had not been planned to meet the needs of people and at times there was insufficient numbers of staff to meet people's needs.

There was a training programme but we could not be assured the training staff had gave them the skills and knowledge to meet people's needs. Recruitment checks had been completed before staff started work to ensure the safety of people.

Medicines were administered and stored safely.

Staff had a basic knowledge of the Mental Capacity Act but people's records did not show people's capacity to make specific decisions had been assessed. This meant people did not have their mental capacity assessed and restrictions may have been placed on people without their agreement or being in their best interest.

People enjoyed their meals and were offered a choice at meal times.

People were supported to access a range of health professionals.

People did not always have their needs planned to be met in a personalised way, which reflected their choices and preferences had been considered. This meant staff may not always have the best information on how to meet an individual's needs and preferences.

People felt confident they could make a complaint and it would be responded to. The recording of complaints needed to improve.

People felt the staff were caring and kind and compassionate. Staff felt supported by the acting manager. Quality assurance processes in the home were not robust and did not identify the gaps in the provision of the service. Records were not always accurately maintained and this was not an effective part of the quality audit process.

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.

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.

We found breaches in 7 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments had not always been completed to ensure staff were aware of the risk relating to individuals.

Staff had an awareness of safeguarding in theory, but in practice they did not recognise when people were not safe.

Staffing levels were not adequate to meet the needs of people.

The storage, administration and recording of medicines was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 had not always been applied to ensure any restrictions to people were made in people's best interests.

Staff were receiving adequate support. There was a training programme but there was no overview to ensure the training was adequate to ensure staff had the skills to meet people's needs.

People enjoyed the meals and were offered a choice.

People had access to a range of health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst permanent staff were caring and tried to promote people's privacy and dignity there was at times a lot of misunderstanding about what this meant in practical terms.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care, which was in

line with their needs or preferences.

People felt they could complain and complaints were investigated.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance system was not adequate to ensure the quality of care was good and lessons could be learnt from analysis of information.

Record keeping was not adequate to ensure records reflected all care was been given to keep people safe and healthy.

Cross Way House Care 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 comprehensive inspection took place on 5 and 6 May 2016 and was unannounced. One inspector and a specialist advisor in nursing and the care of frail older people, especially those living with dementia, carried out the inspection. We visited the service between the hours of 10:00am and 9:30pm over the two days.

Before the inspection, we reviewed previous inspection reports, action plans from the provider, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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.

During the inspection we spent time talking to nine people, three visitors, seven members of care staff, the manager, the nursing manager and someone who advised they were soon to become the nominated individual of the provider for this service. We looked at the care records of nine people and staffing records of three members of staff. We saw minutes of staff meetings, policies and procedures, complaints and records. Certain policies and quality audits were sent to us following the inspection. We were given copies of the duty rota for a month, which included the week of the inspection, and a copy of the training matrix.

We 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 with us. We observed interactions between people

and staff. We received written feedback from two health and one social care professional.

Inadequate

Is the service safe?

Our findings

Staff had received training on safeguarding people and the relevant policies and procedures were available in the home. Staff had a basic knowledge on how to keep people safe and what steps they should take if they felt people were not safe. However, staff had not taken appropriate steps to keep people safe in challenging situations, and this also risked compromising people's privacy and dignity

Some people had behaviours which could be considered challenging to other people and staff. Whilst staff were aware of these there had been no action taken to prevent people feeling unsafe. For example one person whose care plan described them as 'anxious' spent time calling out in the lounge, making it clear they wanted some reassurance. There was no staff in the lounge at this time. Another person started shouting back even louder the word "No". The two people then carried on shouting at each other in a loud voice, a third person then joined in and told the first person in a loud voice, to be quiet using their name. During this time three people left the lounge area. One person seated told us they did not like the shouting and it made them feel scared. In another example one person became distressed by another person's behaviour. The person told us they "I was scared to death." Staff had not taken appropriate action to ensure people were safe and protected from the risk of abuse, despite them knowing the risks of these people's behaviours.

The inability to ensure service users were safe at all times was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst there was evidence there were risk assessments in people's records, these tended to be generalised and not specific to individuals. For example people had risk assessments in relation to the pets in the home, which were clear, despite some people not being able to access all the pets. However, other people who had clear risks associated with their behaviour, which posed risks to other people, staff and themselves did not have clear risk assessments. For example one person who had records of being physically and verbally aggressive, did not have clear risk assessments to inform staff how to support the person at this time so the risks were minimised at these times. Staff told us some of the incidents we have referred to in this report had taken place previously, but risk assessments had not been put in place.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told the home did not use any tool to plan the staffing levels. The manager advised they had identified the current staffing levels were not meeting people's needs and had advised the provider of this and was awaiting a response from the provider. The manager told us in the last four weeks there had been four new admissions but the staffing had not been planned to ensure everyone's needs could be met. All people spoken with told us there was not enough staff. One person told us, "When you use your buzzer at night, you have to wait". Another person told us, "100% need more staff; they do not have time to stay and talk".

Throughout the inspection we saw instances where there were not enough staff to meet people's needs. On two occasions we had to use the call bell alarm system to call for staff as we were concerned about the safety of people.

The home used a static duty rota for week one and week two. All changes to the duty rota were recorded in the diary. This showed a high percentage of staff off sick with agency cover. The skills and competency of staff on duty had not always been considered. On some nights there were staff who had not completed their induction or undergone much training who were on duty with agency staff. During the day three people had needs which meant they needed one to one support for a certain amount of hours. Whilst the duty rota recorded the staff names allocated to these people, they were also on the duty rota to meet everyone's needs. Our observations showed these people did not receive one to one support for the allotted hours.

Staffing levels had not been planned to ensure there was sufficient staff on duty and who had the skills and experience to ensure all people's needs were met. This was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The provider's medicines were kept in a locked trolley secured to the wall; there was a good stock control and a good system for the disposal of unwanted medicines. Medical Administration records were well maintained and matched the records held in the home. We observed a senior care staff member administering medicines, during the two days they were consistently patient and kind towards people. They thanked people for taking the medicine which was good practice.

Requires Improvement

Is the service effective?

Our findings

There was a training programme and a training matrix was kept to ensure staff were kept to date with training. Staff told us a variety of training methods were used, which they enjoyed. One member of staff was very enthusiastic about a recent training course which related to trying to experience how the world feels for a person with a diagnosis of dementia. They advised they had learnt a lot on this course. Whilst there was a full training programme, there was a lack of quality assurance relating to training to ensure the training was equipping staff with the skills they needed to meet the needs of people. For example there seemed to be some staff that lacked the skills of working with people with a learning disability. When looking at the training programme there was little specific training for people with a learning disability. Staff followed a lengthy induction programme, which formed part of the work towards the care certificate. The Care Certificate is the standard employees working in adult social care should meet before they can safely work unsupervised. It gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff felt supported in their roles and received supervision on a regular basis.

The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS). 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).

Staff had heard of the Mental Capacity Act 2005 and could give a simple and brief explanation of what it meant. However they could not recognise the principles of the Act in their practice. Capacity assessments had only been carried out in relation to a person's capacity to understand and give consent for the use of their care plans. No other decisions had been assessed in terms of people's capacity. Staff did not consider they used restraint, but people had bed rails without the use of a capacity or risk assessment. The home had stair gates at the bottom and top of the main stairs, which had also not been considered as restraint. We spoke to the manager about people's capacity assessments all being based on one decision. They told us "We have to have a DoLs and capacity assessment because if they left the building they would not be safe". We pointed out that there were no capacity assessments relating to this in the records we had reviewed. The manager said "This is one of the problems of only being in post for a month".

There was a list available for staff, which detailed who had a DoLs application and whether it had been approved. There was no information in respect of what the application referred to. When looking in people's care records again there was a brief mention of whether people had a DoLs in place, but it gave no detail of what this referred to. This meant people could have been deprived of their liberty unlawfully as staff did not

know the details of what the application referred to in order to inform their practice.

Care plans included DNCPR's (Do not attempt Cardiopulmonary Resuscitation). Some of these showed evidence the issue had been discussed with the person who signed the form. However, in other cases, the medical practitioner had signed the form, and there was no detail about the person having been consulted about the decision. An Independent Mental Capacity Advocate had provided support for three people, which was good practice. However, there was no subsequent feedback from the person about their satisfaction with the service which is the most crucial aspect of the support.
The lack of assessing people's capacity and having regard of the Mental Capacity Act including sufficient details around DoLS was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The majority of people spoken with told us the meals were good and there was always a choice. One person told us, "The food is better than a four star hotel". Other people were not so positive and stated they did not always get what they had asked for. On one day two people had to wait more than forty minutes for their meal. They spoke with each other, one asking the other what the lunch was. The other said "I have no idea, expect it will be something we did not ask for". When the meal arrived, both people said to each other "Told you". Neither of them ate all of their meal. One told us "It was alright but I am not sure what it was". The other person said "It was alright but I don't know if it was what I asked for". We saw one person offered an alternative when they said they did not like what was bought to them. There was a menu displayed in the hallway but it was in a high position and the print was small so few people were able to read and understand the food on offer. There was not a copy in the dining room and pictorial menus were unavailable. Staff supported people in a kind and patient manner. Where necessary people had been referred to the SALT (speech and language therapist) to ensure the risks associated with eating and drinking had been assessed. People's nutritional assessments included screening using the MUST (Malnutrition Universal Screening Tool) which is a five step screening tool, to identify adults who are at risk of malnutrition.

Where it was deemed appropriate people were referred to health professionals as necessary. People told us they had access to health professionals and the staff would support them to access these appointments. Details of the referrals and appointments were maintained in people's records.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were caring, kind and compassionate. A person who told us there was not enough staff also told us the staff were however, "Wonderful". A relative told us the care their relative received had been good, they said, "It can't be bettered".

Permanent staff on duty were caring towards people and treated people on an individual basis with kindness and compassion. However, the lack of numbers of staff and the use of agency staff meant people did not always have their needs met quickly by staff who knew them well. Records did not give sufficient information regarding people's preferences. Therefore unless staff had had previous knowledge of a person and had knowledge of their preferences they would have not known them. For example in one person's care records it recorded the person was 'Obsessed' with sugar. However for one day of the inspection the person sat with 10 meters from a bowl of sugar and could have easily accessed the sugar. None of the staff seemed to notice and the bowl of sugar was not removed. .

It was difficult to evidence that people who were unable to verbally communicate were involved with expressing their opinion on the care they received. One person who was calling out on a regular basis at one time was supported to walk alone along a corridor with a male member of staff. Their care plan made reference to this person preferring female staff to support them. People who were able to express an opinion told us staff asked them questions and involved them in day to day decisions; although one person was frustrated by the layout of the lounge as people permanently walked in front of the TV screen. They also reported how much they used to enjoy musical films, but had not watched any in a long time, they reported there was no facility to watch DVD's in the home.

During the inspection there was an incident which resulted in one person becoming very distressed and frightened and the person was shaking and sobbing. Despite their clear distress they were left with an agency care staff who we were told, it was their first day. This meant the agency staff member did not know the person well. They made the person a mug of tea, offered it to them and then said "Oh be careful it is hot". We felt it and it was still boiling hot. Had the person drunk from it they would have sustained a burn to their lips, mouth and throat. We suggested they waited and took the cup off the person as they were unable to put it down themselves. It was not caring to leave such a distressed person with an agency carer they did not know well.

The provider employed an activities coordinator who had previously worked as a carer. They were skilled in their support of people and behaved in a warm and kind way towards them. The two senior staff and care staff were also responsive and kind. However, the agency staff did not work to the same level of kindness as the permanent staff.

The manager and staff referred to people as "LD's" or "The Elderly". These terms were also used in the daily handover sheet. To use terms such as these reduces people to groups and is not an individualised approach to care and support, which promotes people's privacy and dignity.

The lack of treating people with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People did not receive personalised care which was responsive to them as individuals. It was not possible from the way care plans had been written to establish people had been involved in the development of their care plans. Care plans had the same format and tended to include information in the same areas, rather than being individual to each person's needs and preferences.

The usual pattern was for assessments to be carried out and these then formed people's care plans. However, two people who had moved into the home in the last month did not have care plans or risk assessments. One of these people was described as having "High care needs". This was very concerning as there was no way staff could know the needs, risks and preferences of these two people. The handover sheet used by staff gave a very brief outline of people's needs and lacked detail to give staff a good understanding of people's needs and the ways these should be met. For one of the two people with no care plan there was no information on the handover sheet to give staff information on the person's basic needs.

Pain assessments for people were not used. People with cognitive impairments are sometimes unable to identify or express pain except through non-verbal indicators such as grimacing, shallow and/or erratic breathing, agitation, refusal to get out of bed, loss of appetite and withdrawal for example. If an analgesic (pain killer) has been medically prescribed the person should have a pain assessment at the prescribed times to determine if the 'as and when necessary' (prn) dose should be given (RCN, 2014; NICE 2014, 2015; Dementia UK, 2015). As a consequence the signs a person could have been in pain were not specifically recorded and the lack of guidance left this open to staff personal interpretation which may have varied between staff members.

We noted in one person's records, a medical note that the GP had visited as the person had a 'sore groin'. This had been recorded in an incident in the person's records a few weeks earlier. . There was no other information about this in the person's care plan and we could not see any action had been taken when it was first identified.

People's records contained very little information about individual choices and preferences. It was not recorded if people preferred a shower or bath or at what time they preferred this. Records showed only two of seventeen people had received a bath in the last month. The time people were supported to have a bath or shower was not recorded.

The night handover sheet following the first night of our first day of inspection showed nine people had been supported to have a wash or shower before morning staff came on duty. There was no record in people's care plan reflecting this was their choice. A member of staff who worked nights told us the nights were busy with people 'wandering'. They told us there was an expectation they would get a certain number of people washed and change their continence aids ready for the day staff

In one person's mobility care plan we found the following statement, "I now have ankle weights to slow my walking down". There were no care plans or risk assessments to guide staff about how these should be used.

A staff member told us the occupational therapist had suggested these, but this information was not in their records. There was no consultation with the person about what they thought of their use and their use had not been reviewed on a monthly basis. The manager told us "We hardly use them anymore, maybe one day and maybe alternate days". Again this information was not in their care plan to enable staff to provide personalised care for this person.

Some information was missing in certain areas of people's care plan. For example, when the decision was made for people to use continence support aids the reason for this was not always recorded and there was no record of the involvement of the person. The continence support care plans did not provide guidance for staff about how they could support people to maintain a level of continence and if this was not possible, how frequently continence pads should be changed to preserve skin integrity. We found in two people's records they had sustained moisture damage to their buttocks during the previous three months. (A moisture lesion is a reactive response of the skin to chronic exposure to urine and/or faecal matter). When people had urinary tract infections their short term care plans had not been developed to provide staff with guidance about how they should meet people's care and comfort needs.

Care plans gave little information about people's behavioural support needs. We noted for one person a consultant had been contacted to assess their medicines in relation to their 'anxieties'. Records showed this person had exhibited violent and disruptive behaviour, on more than one occasion. However, there was no information in their care plan to guide staff on how to meet their needs when they were exhibiting this behaviour.

In another area we noted the impact of diabetes was not detailed in people's care plans. There was information about how staff should recognise hypoglycaemia and hyperglycaemia (low and high blood sugar levels) but they did not include the effects of diabetes and how staff could recognise these.

The care and treatment of people was not always person centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Details of the complaints procedure were displayed in the home. Relatives confirmed they had seen this and would be comfortable complaining and felt they would be listened to. A copy of the complaints log was found and this only had one complaint recorded. We were able to see the manager had taken appropriate action and responded to the complainant in the agreed timescale to their policy. We had also passed on details of a complaint to the manager, this had not been recorded in the complaints log, but appropriate action had been taken in relation to the complaint. The manager was reminded to ensure all complaints were logged.

Inadequate

Is the service well-led?

Our findings

It was not possible to determine people were involved with the development of the service. Relatives told us they were listened to and felt they were kept in touch regarding their relatives care. Whilst staff were aware of the values and vision of the home, we were not assured these values were promoted. Part of the home's aims was to provide a secure, relaxed environment with staff striving to maintain people's dignity. People were not always safe, the atmosphere was not always relaxed and it was not respectful to refer to people as LD (Learning Disability) or Elderly as a group. These issues did not help promote the right culture in the home.

The home had a registered manager, but they had not managed the home since March 2016. The provider informed us of this information. The deputy manager had been managing the home and had submitted an application to register with us to become the registered manager. They had a good knowledge of their responsibilities and since taking on the role had sent notifications appropriately to us. Visitors and staff told us they found the deputy manager supportive and had confidence they would take necessary action if they raised a concern with them.

The service at the time of the inspection was not delivering high quality care to all people. There had been a lack of planning and consideration regarding new admissions. In four weeks there had been four new admissions, with two of these people not having care plans and risk assessments in place. Management had not considered the implications of the needs of these people in relation to other people living in the home. There had been no analysis of the staffing levels to ensure they could meet people's needs. Lastly whilst there was a training programme there had been no consideration as to whether sufficient staff had the skills to be able to care for the new people coming to live at the home. This demonstrated a lack of leadership and good management skills.

The home had a programme of quality audits and an audit schedule over a twelve month period, which related to the five domains of CQC inspections. The service also had an external professional do a quality audit on the home on an annual basis.

We found the service was not safe and have rated the domain inadequate. We looked at the quality audits which had been carried out in January 2016, which related to the safe domain. We were concerned as these did not identify any concerns relating to the safe domain, which contradicted our findings. It was noted the audit did report staff felt pressurised around meal times and assisting people with night routines especially when call bells rang at the same time. Whilst this was recorded there was no recorded action against this, so there was no process to monitor the audit and see if the situation had improved. From the ten quality audits seen, none had an action plan completed, which was at the end of each audit. The quality assurance process was also ineffective in terms of monitoring accidents and incidents. There was no overall analysis of incidents and accidents, which meant there could be no learning from these recordings.

Records were either not made or not accurately maintained and needed to improve. For example the recording of incidents and accidents needed to be improved in the home. We found recordings of incidents

in people's records which had not been recorded as an incident so were therefore not investigated or monitored. While some people had body maps which showed a bruise, others did not. This meant the recording was poor. People's food and fluid charts did not contain a daily fluid intake target and there were no daily totals recorded. This meant it was not possible for staff to monitor people's fluid intake accurately. Staff were not specific in their recording, for example they would record "Bowl of Weetabix ate half" when there was no record of how much a bowl contained.

This failure to ensure accurate records and effective systems to monitor the service to drive improvement was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a lack of assessing people's capacity and having regard of the Mental Capacity Act including sufficient details around Deprivation of Liberty Safeguards.

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 Service users were not safe at all times.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always person centred.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of effective risk assessments in place to ensure the safety and welfare of people.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure accurate records and effective systems were maintained to monitor the service to drive improvement.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels had not been planned to ensure there was sufficient staff on duty and who had the skills and experience to ensure all people's needs were met

The enforcement action we took:

Warning notice