Premier Care Homes Limited

Picktree Court Care Home

Inspection report

Picktree Lane
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21 October 2020
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28 October 2020
05 November 2020
16 November 2020
11 December 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Picktree Court is a residential care home providing personal and nursing care to 77 people aged 65 and over at the time of the inspection. The service can support up to 88 people across three floors.

People's experience of using this service and what we found
Care delivery in Picktree Court was undermined by practices which were not safe. The management of accidents required improvement together with other safety issues. Some unexplained injuries were not reported to the local authority safeguarding team or CQC. We were not assured PPE was always used appropriately in the service or that staff were social distancing as they entered the care home.

The regular weighing of people had been stopped during the COVID-19 pandemic which meant staff were unable to detect people's weight changes. Fluid charts required further work to monitor people's intake.

People's individual needs were described in care plans. Improvements to the management of complaints, end of life care and activities were required. We have made recommendations about these areas of practice.

Relatives able to access video calls without people becoming distressed were positive about using electronic communication systems. Other relatives were worried about the impact of isolation on people. One relative said, "I think she is becoming withdrawn, bored and lonely."

The culture of the service was not always open and transparent. Weekly emails from the provider to relatives contained information which was contrary to information we gathered during the inspection. Opportunities to learn lessons were missed.

People were not always 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. Policies and systems outlined good practice but they were not always followed. We have made a recommendation about this.

Staff were caring and supportive towards people and protected their dignity. Relatives appreciated the relationships they had with staff during the COVID-19 pandemic. Comments included, "The staff and management are all very caring and helpful and approachable" and "In these horrendous times all staff have been resilient and remarkable."

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

Rating at last inspection
The last rating for this service was outstanding (report published March 2018).

Why we inspected

The inspection was prompted in part by information which indicated a person using the service died of injuries sustained in the home. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident and falls sustained by other people in the care home indicated concerns about the management of falls. This inspection examined those risks.

The overall rating for the service has changed from outstanding to requires improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Picktree Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions and good governance. In addition, since the last inspection we recognised that the provider had failed to notify us of serious injuries. This was a breach of the Care Quality Commission (Registration) Regulations.

We served a fixed penalty notice on the provider for failing to notify CQC of serious injuries.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our effective 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?

Good

The service was 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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Picktree Court 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by four inspectors, an expert by experience and a specialist advisor in nursing. One inspector gathered information from the service, whilst three inspectors carried out two site visits. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They spoke with relatives by telephone.

Service and service type
Picktree Court is a 'care home'. People in care homes receive accommodation and nursing or 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.

Notice of inspection
Inspection activity started on 21 October 2020 and ended on 11 December 2020. We contacted the registered manager to announce the start of the inspection on 21 October 2020. We carried out two site visits on 28 October and 5 November, the first of which was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We asked the registered manager to send out an email to all relatives with an email address to ask if they would like to give feedback to the inspection team. Twenty-four relatives responded to the inspectors via email. We also spoke with 15 relatives by telephone.

We spoke with 23 members of the organisation including the director, registered manager, assistant manager, senior care workers, care workers and the activities coordinator.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at six staff files in relation to recruitment and staff supervision. The registered manager sent us a variety of records relating to the management of the service, including policies and procedures which were reviewed by the inspection team.

After the inspection
Following our site visits we continued to seek further information from the provider.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- Care and support was not always delivered in a safe manner, and action to mitigate risks had not always been taken.
- Staff did not follow good practice guidance in relation to falls. The registered manager had carried out audits of the falls using the number of falls per person, their location and possible cause but had not considered the time when falls occurred.
- The fire risk assessment did not follow national fire guidance. Staff confirmed they were trained to evacuate people horizontally from one fire compartment to another but did not have the equipment or training to progressively evacuate people from the building. Advice given to staff by the management team on what to do if they suspected a fire was inaccurate.
- Protocols to describe when medicines were required on an 'as and when needed' basis were not being used by staff. The administration of topical medicines was not always documented correctly.
- Staff carried out regular safety checks on the building and its contents. Care plans for the use of bed rails included an assessment of the safety risks. Staff reviewed people's bed rails plans and wrote 'bed rails in situ' without documenting they had checked the rails in line with the risk assessment. Checks carried out by other professionals were out of date.

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

- Staff administered oral medicines in a safe manner. One relative said, "They manage her meds, and they get it right. She does take them."
- Following our site visit the registered manager told us they had reviewed processes and developed systems to improve the management of 'as and when required' medicines.
- Relatives told us, "It feels very safe. We are very satisfied with the care" and "I definitely feel she is safe. When I was able to visit I visited every day. I could see she was getting her tablets regularly and was washed regularly. I don't have any worries." Another relative said, "During the time that [person] has been there I believe that she has been well looked after and I appreciate the care."
- The provider had other risks assessments and testing procedures in place which described what actions they had taken to keep people safe. Checks on lifting equipment needed to be updated.

Systems and processes to safeguard people from the risk of abuse

- Staff did not always follow systems and processes in place to safeguard people from abuse.

● Information provided by the registered manager showed whilst staff had been trained in safeguarding people, safeguarding concerns had not always been raised with relevant external professionals when staff documented unexplained bruising to people.

This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● During the pandemic the registered manager and staff had learned lessons regarding COVID-19.
● When concerns had been raised about the service, the director did not approach investigating these concerns in an open manner. Subsequently, they were not reflective in their approach in order to use learning from complaints to drive improvement within the service.
● Lessons had not been learned in relation to falls.

This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider followed safe recruitment procedures.
● The registered manager acknowledged that during the COVID-19 pandemic staffing the home had been challenging. Staffing levels were determined using a staff dependency tool. The provider's dependency tool did not provide a column to calculate care hours for people who were totally dependent. Following the inspection, the provider told us care hours are above 100% and they allowed for individuals being more dependant or receiving end of life care.
● Staff opinions varied on whether there were enough staff on duty. Whilst some staff felt there were enough to meet people's needs, other staff felt there were specific times, such as night shift, when more staff were required.
● Relatives also had differing views about staffing levels. One relative said, "I try to ring every other day. I know they are busy. The phone is answered quite quickly, and the staff are helpful." Another relative said, "The staff are always very busy. When we were allowed to visit, if I needed to talk to staff it could be difficult to track someone down."

Preventing and controlling infection
● Arrangements had been put in place to prevent and control the spread of infections. Staff understood the need to observe social distancing with people who lived in the home. Some staff entered the building and the ground floor at the start of their shift without being socially distant from each other before they used PPE.
● Staff understood the need to wear PPE and when to change it. However, photographs shared with us during the pandemic showed staff were not always wearing full PPE when in close proximity with people. We have signposted the provider to resources to develop their approach.
● Other infection prevention and control (IPC) guidance was followed, for example in relation to admitting new people into the home, testing and cleanliness. The IPC policy was up to date.
● Cleaning schedules were in place to ensure areas of the home were cleaned on a regular basis. The home was clean, tidy and well-presented. In a resident's survey one person said, "The bathrooms and toilets are spotless" and "I like the cleanliness of the home.'

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 outstanding. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Staff did not always support people to maintain healthy lifestyles. Staff were advised by the management team to stop weighing people during the pandemic. Staff had written in people's care documents, "Not weighed due to COVID-19." Consequently, some weight loss was not addressed in a timely manner.

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

- Staff had contacted external professionals for support when people's health needs changed. For example, GPs, dieticians and the district nursing team.

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

- People's fluid intake was not robustly monitored.
- Staff used food and fluid charts to monitor people's intake. Fluid charts did not have a target amount documented and people's intake was not always totalled to ensure they achieved minimum intake to maintain hydration. Oversight of completion of these records was not documented.

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 breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Whilst some relatives told us people enjoyed the food and had gained weight, one relative was concerned about a person being hungry. In the resident surveys people had reported they enjoyed the food.
- Relatives were concerned about the quality and the repetitiveness of the food offered to people who required a soft food diet. Staff had echoed these comments in their recent feedback to the management team. The registered manager included this issue in his action plan to address with the cook.
- Other relatives said, "Staff support her (with eating) and she seems happy with that. She complains about the food but there is always an alternative. I used to take food in, but there are restrictions now, so it can't be home made, things have to be packaged." Following the inspection, the provider told CQC relatives were permitted to deliver food to people during the pandemic, as long as they were in original sealed bags that could be disinfected.

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

● The provider had a policy in place about the MCA which reflected good practice including the two-stage test required to assess a person's capacity.
● Staff had documented the first stage of the MCA. In weekly emails to relatives, the registered manager had requested the recipients give their consent a range of issues. This approach does not presume people have capacity to make their own decisions.

We recommend the provider reviews their approach to seeking consent.

● Staff had submitted appropriate DoLS applications to the local authority to seek authorisation to deprive people of their liberty.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices had been assessed. Pre-admission assessments were carried out by staff. During the COVID-19 pandemic the registered manager relied on information provided by other professionals to obtain background and health information.
● Care plans provided staff with information about people's preferences and their individual needs.

Staff support: induction, training, skills and experience
● Staff received support from the management team to carry out their role. Inductions were carried out with new staff.
● The registered manager maintained a training matrix which showed staff had received training in topics relevant to their role.

Adapting service, design, decoration to meet people's needs
● Corridors were wide and suitable for the use of wheelchairs. Handrails were available to support people's mobility. In the resident surveys people said, "The lounges are very comfortable" and "The dining room is very pleasant. "
● Signage was in place to orientate people to bathrooms and toilets. Signage to assist people locate their bedrooms would further assist people living with dementia.

Good

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 outstanding. At this inspection this key question has deteriorated to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff treated people with kindness and empathy. Relatives felt staff treated people with respect. They said, "The girls are lovely, and I feel they are doing their best" and "They're very friendly and very good. When I was able to visit, for example, if clothing was missing, they'd take me down to the laundry to try and find it."
- Some relatives were concerned about people becoming mentally low when they were isolated. Whilst others felt staff were doing their utmost to support people. Staff had raised the lack of contact with families having an adverse impact on people. In their action plan, the registered manager agreed times were challenging but the service had carried out video calls and face to face visits.
- Relatives appreciated the care given to people whilst visiting was restricted. Relatives said, "All staff have worked so hard caring for all residents" and "The staff are all so approachable and to be honest feel more like friends."

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

- People were supported to express their views and make choices about how they wished to receive their care. This included where they wished to eat their meals.
- Residents' surveys carried out in 2019 asked people for their views and indicated people were happy with the care provided. People said, "I am very well cared for and watched over" and "They are all amazing, wonderful people."
- Group chats were held with people on each floor to discuss activities in the home.

Respecting and promoting people's privacy, dignity and independence

- Staff understood how to protect people's dignity and privacy. Personal care took place behind closed doors.
- Staff described ways in which they promoted people's independence such as eating or walking. They demonstrated how they enabled people to be more independent whilst keeping people safe.

People's personal information was kept secure by the provider.

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 good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

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

● Arrangements for video calls which were put in place to enable people to avoid social isolation were successful for those people able to use this type of technology. Staff had spent considerable time providing video calls which relatives valued. Relatives said, "The Zoom (video) calls with us as a family have given us some reassurance that mum is okay" and "The introduction of regular Zoom calls has enabled some degree of contact which has eased the separation forced upon everyone by COVID-19."

●There was poor mobile reception in certain parts of the home which limited people's contact with their families who had supplied mobile phones and electronic equipment. The management team had introduced outdoor visits using gazebos in the car park. Whilst some relatives valued the opportunity to see people, others were constrained by people unable to access the gazebos or who felt cold sitting outside.

● Relatives were concerned about the impact on people being isolated in their rooms and described how they thought people had just given up. One relative said, "She is a shadow of her former self." Another described their parent as 'losing their feistiness.' In resident surveys one person said, "I like the activities."

● The activities plan included video calls and communal events including coffee mornings with one to one contact time on a Wednesday. One relative said, "They could do with more staff at the moment because they are doing Zoom calls, so activities have fallen off. They can't do it all. Activities seem to have mostly stopped." The registered manager told us activities such as making decorations, hairdressing visits, and birthday treats had taken place. Staff confirmed the communal activities were not always possible due to COVID-19 and had recorded in monthly evaluation statements there had been no activities for some people.

We recommend the provider considers people's personal activity needs to promote their well-being.

Improving care quality in response to complaints or concerns

● Complaints made to the service were handled inappropriately. One professional stated a complaint had, "Not been handled in an appropriate or professional manner by the management of the home."

● The provider's complaints policy required verification as to whether an advocate or friend had permission to speak on behalf of a person and act on their behalf.

● The provider told us they had not refused to investigate any complaint made about the service based when verification was not forthcoming

We recommend the provider consider how they respond to complaints and the impact of their responses on the complainant to ensure future good working relationships.

End of life care and support

● Staff had drawn up end of life care plans which included the wishes of people and their relatives. One relative said, "We had conversations about end of life, we signed the DNR and its reviewed annually."
● At the beginning of the pandemic the management team had refused to accept emergency health care plans drawn up by local health care professionals as they believed they contained inaccuracies. The management team also believed people had not been sufficiently involved in the development of the plans to explain their end of wishes. To support relatives making a decision, the provider sent out an email to relatives in April 2020 giving reasons why they believed care homes cannot provide suitable care for people with COVID-19.

● Due to COVID-19 the provider had introduced guidelines on end of life care which included people only being allowed to have visitors for two hours and visitors were not to use the lift. The guidelines were incompatible with the care and practice delivered by staff. Positive feedback was received from a relative whose experience included being permitted to remain in the care home at the end of their family member's life. They said, "I was allowed in to stay with her and I had a whole week for us to be together, to share memories and to assure her I was there."

We recommend the provider reviews their approach to end of life care, so that it includes a full consideration of the needs of people and their visiting relatives.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.
● Person centred information was contained in people's care plans. Staff had written people's care plans after gathering information about their needs and preferences.
● Relatives confirmed they had read care plans. One relative said, 'Yes, I've seen it and I think I'm supposed to review it but have not had the chance since COVID. I was really impressed when I first saw it, I feel they noticed lots of things about (person) that I hadn't expected them to – it's so reassuring."

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.
● Staff were aware of how people's communication needs were to be met. Guidance was provided in people's care plans on how to assist people to receive information when they lived with a sensory impairment. One relative said, "Staff will write things down for her to read if she's not hearing what they are saying."

Requires Improvement

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 good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to submit statutory notifications regarding people who had sustained serious injuries whilst living at Picktree Court.

This is a breach of Regulation 18: Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009. This regulatory breach is being dealt with outside of the inspection process.

- Audits were carried out by the registered manager. The falls audit was of insufficient depth to identify the timing of people's falls. Falls risks were not suitably addressed.
- The provider needed to use agency staff for nursing cover. The registered manager required agency staff to complete risk assessments in relation to COVID-19. Checks were not independently carried out by the provider using the Nursing and Midwifery Council to identify if nurses were registered or there were any restrictions on their practice. Agency staff inductions were not documented.
- Continuous learning from complaints was undermined by the stance taken by the director in response to some concerns raised about the service. Opportunities to consider improvements to the service were missed.
- Records in the service were not always completed. Fluid and topical medicines charts required improvements. Protocols for medicines required on an as and when basis were not in place.

This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had implemented the COVID-19 testing programme for people and staff.
- Staff and relatives found the registered manager to be approachable. One relative said, "I've had most dealings with [registered manager]. He's really personable and seems to be on the ball." Relatives valued the registered manager's advice and support when their relatives were admitted to the service.
- Staff surveys were generally positive about the home and identified areas for improvement. The registered manager had considered areas for improvement and documented what actions they would take. One relative said, "It's well run, that's the most important thing for me. We're very happy with everything in the care home."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● An open and empowering culture was not prevalent in the home. The registered manager asked families for supportive comments only when CQC undertook this inspection. Some relatives said they had not seen their relatives for so long, which made it difficult for them to comment. One relative said, "As no-one has been permitted to enter the home for over seven months it is impossible to assess the quality of care currently provided."

● The registered manager sent weekly updates to families during the COVID-19 pandemic. Whilst a significant number of relatives appreciated the updates, others had concerns about their content. Some relatives appreciated the emails, others described them as 'unnerving' or 'difficult to read'. Following the inspection, the registered manager provided the option for relatives to opt out receiving these emails.

● Relatives said when they had raised issues, they had been told how much more COVID-19 had cost the business. Some relatives told us they were worried about any impending uplift in care costs. One relative said, "We feel the care home is run too much like a business rather than a care home for the residents." Following the inspection, the provider told us they found these comments to be unjust.

● Professionals described having had challenges in their relationship with the senior management team. Following the inspection the provider told CQC the registered manager had not experienced any difficulties with healthcare professionals.

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

● The provider met the requirements of the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The engagement of people using the service had been curtailed due to the COVID-19 pandemic. This included reducing resident meetings and a completion of surveys. Surveys had been carried out prior to the pandemic and in October 2020; the results of the surveys had been aggregated and actions put in place to address the issues raised.

● Before 2020 minutes of staff meetings showed staff had been engaged in discussion and the registered manager had drawn up action plans in response to those discussions. More recently staff meetings had been set up with different staff groups. The minutes of the staff meetings contained identical wording with little or no evidence of staff contribution.

● The registered manager sent out weekly emails to relatives where they identified staff who had left the service and inappropriately shared the reasons why. We received other information which was inconsistent with the information shared in these weekly emails.

● A relative described their involvement with the service and said, "There are relatives' meetings usually once or twice a year. We're invited into one big room and with staff. We go through things like food, menus, laundry and it's a chance to discuss and ask questions. The registered manager is very frank about things." Other relatives said they would have liked to continue their involvement in the service and be invited to video call meetings during the COVID-19 pandemic, where they could have supported each other.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment people was not always provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not always operated effectively to protect people from abuse. Unexplained injuries were not reported to the local safeguarding team.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were insufficiently robust and failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

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
Treatment of disease, disorder or injury	The provider failed to notify the Commission of serious injuries.

The enforcement action we took:

We issued a fixed penalty notice.