Runwood Homes Limited

Highview Lodge

Inspection report

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Date of inspection visit:
17 October 2023
20 October 2023

Date of publication:
11 January 2024

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Highview Lodge is a residential care home providing personal and nursing care to 53 people at the time of the inspection. The service can support up to 77 people in 1 purpose built building.

People's experience of using this service and what we found
At the last inspection we found the provider did not have robust governance systems to monitor the service and address shortfalls in the home. There had not been enough improvement made at this inspection and the provider remained in breach of regulation. Well led had been rated requires improvement at the last 3 inspections.

At this inspection we found there had not been enough improvement and it had remained in a negative rating. Ineffectiveness of governance systems was a concern at the last inspection and the provider submitted an action plan stating how they would make the required improvements. This had not happened. The registered manager had left since the last inspection. There had been an additional 3 managers, including the manager at the time of this inspection who had only been in post 3 weeks prior to the inspection. Feedback from people, relatives, most staff and professionals was that the management had been inconsistent and communication needed to be improved but the provider had not yet made any positive changes.

At our last inspection we found that people's safety was not always promoted. There had not been enough improvement at this inspection, and we found shortfalls in relation to medicines management, individual risks such as pressure care, falls and pressure care.

People were not always supported by sufficient numbers of staff. We found people had care missed or delayed as staff were often busy. This also impacted on mealtimes as there was not enough time elapsing between meals.

People and relatives told us that staff were kind. We saw staff were kind and caring. However, due to demands on their time, tasks were at times missed. Staff worked hard to try and minimise the impact of this. Staff felt they had enough training, which was up to date in most cases.

Care plans were in place but at times this included inconsistent information which made it unclear about how people needed their needs met. Due to staffing issues, care was not always personalised, for example, the time people went to bed, the gender of staff supporting them and how they spent their day.

Some people and relatives told us they would like there to be more to do to help prevent social isolation. There were some activities in place but these did not reach everyone as some people were cared for in their rooms and some were eating at the time.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

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 requires improvement (published 14 October 2022).

Why we inspected
The inspection was prompted in part due to concerns received about management, poor care and staffing. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

Enforcement and recommendations
We have identified breaches in relation to safe care and treatment, person centred care, staffing and governance. You can see what action we have asked the provider to take at the end of this full report.
We have made a recommendation about the improving communication aids.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Follow up
We will request an action plan for 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. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

Highview Lodge

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
This inspection was carried out by 2 inspectors.

Service and service type
Highview Lodge 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.

The service had a manager who had applied to be registered with the Care Quality Commission. Being a registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection 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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and 5 relatives and friends about their experience of the care provided. We spoke with, and received feedback from, 15 members of staff including the registered manager, deputy manager, care workers and ancillary staff. 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 reviewed a range of records. This included 5 people's care records and multiple medication records. We looked at a variety of records relating to the management of the service, including policies and procedures.

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 requires improvement. At this inspection this key question has remained the same. 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
● At the last inspection we found the provider did not ensure people were supported safely. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There had not been enough improvement made at this inspection and the provider remained in breach of regulation 12.

● There was an overview of accidents and incidents in the home. However, when we reviewed the accidents we found that there was a higher number of falls in the evening and during the night. No action had been taken in response to this analysis.
● 13 staff had not attended a fire drill. 4 of these staff were night staff which increased risk of potential harm during a shift when there were reduced numbers of staff on duty.
● People told us they felt safe when staff supported them in most cases. However, 1 person said when there was unfamiliar staff supporting them they felt less safe as they were not confident they knew how to support them.
● There were a low number of pressure ulcers recorded in the home. However, for a person who had sustained a pressure ulcer, the required pressure relieving equipment was not in place on it first developing and we saw it was not in use on the day of our visit.
● People had bedrails and in most cases protective bumpers were fitted correctly. However, 1 person had a large gap as the bumpers did not cover the whole rail. This increased the risk of entrapment. The risk assessment said, 'must adjust their bed rails so they are up and that the 'bumare' positioned in the correct position'. This included the text error so was not clear and did not reflect if the bumpers fitted the bed rails. The plan also said ensure the person had their call bell, but another section stated they were unable to use their call bell.
● Mattresses checked were set correctly, and some repositioning for those in bed was being carried out. However, for those dependent on staff for mobility and in need of continence care there was increased risk. There were gaps in records for some people's repositioning. There was a missed opportunity to promote healthy skin and continence care before meals which meant people were sitting for longer periods of time and this increased the risk for an impact on their skin integrity.
● There was refurbishment work in progress on the first day of our visit. However, we had to intervene as a trailing cable posed a hazard for people living with dementia and or impaired vision. There was a risk assessment for the works, however it did not include safety checks from a manager. We did not observe the management team doing safety checks during the day.
● We saw care plans gave inconsistent information. A care plan for a person who was at risk of choking, gave

2 different food levels of food consistency. This was also identified as a concern at our previous inspection.

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

Using medicines safely
● People did not always receive their medicines in accordance with the prescriber's instructions.
● We observed a person who was living with dementia, on a unit with other people living with dementia, being left with a drink with covert medicines in. There was no staff around to supervise the person taking their medicines or to ensure another person did not consume the medicines. There was no risk assessment for this.
● We checked a random sample of medicines and records and found some discrepancies. For example, a person's medicine had been missed and the following day this had not been identified by the staff member doing the physical count of the remaining medicines.
● Another person had changed pain relief patches. However, the body map for the new patches had not been completed. The previous map ceased on 23 September 2023 and there was a gap of body map recording from 24 September to 17 October 2023. This meant there was no record of where the patch had been administered or if the used patches were removed.

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

Staffing and recruitment
● We found that there were not always enough staff available to meet people's needs. For example, people were not offered to use toilet facilities before meals and breakfast was not served for some until only an hour before lunch and during the afternoon shift. When staffing numbers dropped due to housekeepers no longer being on duty, people were having a increased number of falls. This had not been identified and actioned by the management team.
● People told us the staff were helpful but they had to wait for support. A person said, "I don't feel so good. There is no-one around." We also observed an incident between 2 people and there were no staff around. A person said, "I guess we're ok but there isn't anyone around now." We observed people waiting for support and on 5 occasions had to intervene to ensure people were safe and had their needs met.
● Staff told us there needed to be more staff. They told us breakfast was late, people did not always get taken to the toilet before meals and shortcuts were made with medicines. One staff member said, "We normally try and get people into the dining room but we haven't had time."
● The management team told us staffing levels were calculated using a dependency tool. However, our observations, and feedback received, showed that the management team were not out on the units seeing the impact of staffing numbers.

The lack of sufficient staffing numbers was a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding concerns were reported appropriately. Information about how to report concerns was available.
● People told us they felt safe and they could speak up if worried about something.
● Staff had received training and knew what to do if they had concerns about abuse.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visitors in care homes
● People's friends and families were able to visit without restrictions.

Learning lessons when things go wrong
● The management team shared events, incidents and complaints with the staff team. A staff member said, "Lessons learnt folder in place and available to everyone."
● There had been a lack of sharing about events and incidents with people and their relatives. There were plans to improve this.

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.

Supporting people to eat and drink enough to maintain a balanced diet
● People gave mixed views about the food. A person said, "Food is odd considering all old people, lost weight when I moved in because if change of food."
● People were asked their preference at the mealtime. However, for several people, breakfast had been given only 1 hour before lunch was served. As a result, several people left their main meal. We overheard comments such as "No, thank you. I really just don't want anything right now" and "I'm just not hungry." A staff member said, "We sometimes struggle to have everyone up and ready for the day in good time due to the amount of doubles. This can mean that breakfast is late and then the residents don't eat as much at lunch time."
● Drinks and snacks were offered through the day. Staff were aware of any dietary needs. However, a person was noted to not be keen on milkshakes but their plan stated they were to be given to the person twice a day with no alternative considered.
● The management team monitored people's weight. Where needed, people had meals fortified to help encourage a higher calorific intake. However, the short gap between meals had not been considered.

Staff support: induction, training, skills and experience
● People and relatives told us they felt staff were trained for their roles.
● Staff felt they had enough training but views on support provided was mixed. A staff member told us, "We get enough training." Another staff member said, "I haven't had any supervision."
● We saw staff had received training in the required areas. This included moving and handling, dementia care, health and safety and safeguarding adults. Most was up to date but some staff were due for refresher training.
● Staff were seen to be working in accordance with their training in most cases.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People were encouraged to choose how they wanted to spend their day. Staff gave people choice and listened to their response. However, as staff were busy, some people did not get to choose. For example, people stayed where they were such as in their bedroom, or in the lounge for meals. This included preferences in relation to gender of staff supporting them, staffing issues meant this choice was not adhered to.
- Where needed, people had capacity assessments and best interest decisions recorded. For example, to manage risks and receiving the care needed.
- DoLs applications were made in accordance with people's needs and there was a tracker for monitoring their progress.
- It was recorded if a family member had power of attorney giving them authority to make decisions on a person's care needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- People had their needs assessed before moving into the service.
- People were supported to have health and social care appointments.

Adapting service, design, decoration to meet people's needs
- The building was having some refurbishment carried out. The environment had improved since the last inspection.
- Most bedrooms were personalised with people's belongings.
- Some bedrooms had personalised picture boxes on the doors, this was a work in progress and had not yet been completed for everyone.

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 good. At this inspection this key question has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
● People and their relatives told us staff were kind and caring. A person said, "Most of them (staff) are kind." Another person told us staff at night were less friendly but was unable to give any examples. A relative told us, "Care staff are amazing, hardworking, and so friendly." Another relative said, "I'm happy with carers, can't fault them."
● Staff were kind, attentive and respectful when speaking with people.
● However, on the first day of our inspection we noted 2 people's names were spelt incorrectly on their doors. We raised this with the management team. On our second visit, 3 days later, the names remained incorrect. In addition, both of these people lived with dementia, and this would not help them orientate themselves.
● Most relatives we spoke with told us that their family members clothes frequently went missing and did not return from the laundry. They also said there was often a shortage of towels and flannels. They told us despite raising these concerns with the management team on many occasions, there had been no change to this.

Supporting people to express their views and be involved in making decisions about their care
● Staff listened to people and their views were reflected in their care plans.
● However, we found care was delivered in a way which was task led with everyone following the same timeline. In addition, where people had a preference about the gender of staff supporting them, this was not always respected. We saw male staff delivering care to people who preferred female staff. This was often unavoidable as units were staffed with a male staff team.

Respecting and promoting people's privacy, dignity and independence
● A health professional gave a consultation in a communal area which had other people and visitors in. Staff did not challenge this. This meant staff had not recognised the impact on people's dignity and privacy.
● Doors were closed when people were in bed or receiving care.

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 changed to requires improvement. 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

- While people and their relatives were positive about the care staff, they gave mixed views about how people's care and support needs were met. Some people said their needs were met, while others raised concerns. A relative told us, "A few times I have asked for [person] to be bathed as they looked grubby or their hair needed washing." Another relative said, "My [person's] fingernails always have faeces on them. I notice staff do not wash her hands before meals or clean under her fingernails."
- We saw that in most cases care needs were met. However, we did observe some people had dirty fingernails and not everyone was dressed for the colder weather. We asked people if they felt cold as their hands were cold to touch and they told us they were. We needed to offer a jumper to a person as they were unable to call for assistance and staff had not provided one.
- Care plans included information to help ensure staff had all information needed to support people. However, the plans were not always consistent and at times missed plans for specific care needs. For example, a section for someone said needs support of 1 staff member, then in a different section it says 2 staff needed, another did not include plans for diabetes or mental health needs.
- Care was not given at individualised times. On our second visit we found most people in bed at 6.50pm. A staff member said, "Everyone goes to bed at around the same time." Care plans did not always include people's preferred routines so we were unable to determine if this was staff routine or people's preference.

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

- People gave mixed views about if they had enough to do. A person said they would like to join in with things in the communal areas, but they spent the whole day in their room. Their notes stated they had left their room, but they did not.
- A relative said, "I have never seen [person] involved in any activities but I'm not sure if that is because she doesn't communicate so can't take part or if she just wanders off. They do have pictures of residents doing activities but never seen any of [Person]." Another relative said, "I do feel sometimes more activities would be nice as [Person] seems to be sat in the lounge just watching TV, they look a bit lonely, they would love I think to join in more with group activities."
- People in a lounge were doing some colouring on the day of inspection. In another unit a staff member tried to start a game on the floor while people were trying to eat breakfast, so it did not get much interest.
- On our visits, people who stayed in bed, or in their rooms, did not have any social interaction, other than staff providing care tasks. A person we spoke with said, "I was glad to have a talk as I have no one to talk to often."

There was a need to ensure care was person centred and met people's needs, both physically and socially. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 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.
● When the care plan was developed at the start of supporting a person, any specific need or preference in which people communicated was explored. The service can give all relevant documentation in large print, easy-read format or the person's preferred language as needed.
● People and relatives told us staff communicated well and in a way that met people's needs. We saw people's care plans included the communication needs for people and how staff should support people to aid effective communication.
● Staff were patient, friendly and helpful when communicating with people. However, for 1 person who was extremely hard of hearing, they had not introduced aids such as a whiteboard, to help communicate. The person used a notebook and pen. In addition, they could not hear when people knocked on their door, which resulted in them being made jump when staff entered their room.

We recommend the provider assess to see if there is a needed for a visual aid to ensure the person knows when someone is entering their room and if the fire alarm should sound.

Improving care quality in response to complaints or concerns
● People and their relatives told us they would be confident to raise concerns to the care team if the need arose. However, they felt less confident of it being resolved if it was raised with the management team. Relatives told us communication from the management team needed to be improved.
● There was a system in place to record and respond to complaints.

End of life care and support
● At times the service supported people at the end of their lives.
● Care plans detailed what support would be needed, and people's preferences.

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 requires improvement. At this inspection this key question has now changed to inadequate. 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● At the last inspection we found the provider did not have robust governance systems to monitor the service and address shortfalls in the home. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

● Well led had been rated requires improvement at the last 3 inspections. At this inspection we found there had not been enough improvement and it had remained in a negative rating.
● Ineffectiveness of governance systems was a concern at the last inspection and the provider submitted an action plan stating how they would make the required improvements. This had not happened which left people at continued risk of poor care or unsafe care.
●The registered manager had left the service since the last inspection. There had been an additional 3 managers since, including the manager at the time of the inspection who had only been in post 3 weeks prior to the inspection. This meant there was no stable leadership in the home and left people at risk of receiving a poor standard of care.
● Feedback from people, relatives, staff and professionals was that the management had been inconsistent and not yet made any positive changes. A staff member said, "As to last few months with no home manager, things have slipped badly despite staff trying to keep the care at a reasonable level."
● People did not know the manager. Relatives also did not know the manager. A relative said, "As yet I have not met the manager or even know their name, will they stay?"
● Staff gave mixed views about the leadership. A staff member said, "New manager in place has lots of ideas and seems very knowledgeable. The home is very disjointed at the moment, hopefully they can join everything up to run more smoothly. Communication throughout the home needs to improve." Another staff member said, "We are not appreciated, not even had a meeting. I'm scared to speak up."
● People, relatives and some staff told us, and our observations found, the manager did not spend time around the home. In addition, aside from a manager from another home who was there to support the team, other senior managers visiting for the day moved around the home, talking on phones, and not engaging with people as they walked past them. This did not demonstrate a culture of it being people's

home or help them understand people's experiences.
● Audits and quality checks were completed and signed off. There was an overarching action plan. However, these audits had not identified the areas of concern we found on inspection. For example, shortfalls in care needs being met, safety concerns and impact of staffing levels.

This was a continued breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Following our inspection visit the management team advised us of steps they were taking to mitigate risks. This included making some changes to staff teams and deployment, additional training, more support and supervision for the manager and staff team, and establishing relationships with people, relatives and health 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 management team needed to improve how they communicated about events and incidents in the service with people, relatives and professionals.
● The manager reported relevant events to external agencies as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives gave some negative feedback about how the management team engaged with them. A person said, "I don't get asked if I'm happy." A relative said, "I find it quite upsetting that there was not an email or any communication to let family members know that [manager] left and the same with [another manager], I think we should have been told instead of hearing it from staff."
● There had been a shortage of planned opportunities, such as meetings, to gain people's views during the manager changes. There were plans to reintroduce these more regularly. A relative meeting was planned for the day of our inspection visit.
● Staff did not have regular meetings, this was planned to restart. Some said they could share their views, others did not feel confident to do so.

Continuous learning and improving care
● The management team reviewed events and shared any learning with the staff team.
● The manager was completing an action plan to help drive improvements the service. However, the provider had not ensured there had been sufficient learning and action to improve care since the last inspection, nor had they taken learning from their other locations recently inspected.

Working in partnership with others
● The team at Highview Lodge worked with health and social care professionals to help ensure people had their support needs met appropriately.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive care that was personalised and met all their needs consistently.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff deployed to ensure people's needs were consistently met.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's safety was not consistently promoted and this placed them at risk of harm.

The enforcement action we took:
We issued a warning notice to ensure they took swift action to make the required improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they applied effective governance and leadership and this impacted on people.

The enforcement action we took:
We issued a warning notice to ensure they took swift action to make the required improvements.