Ms Fola Omotosho

Tosh Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 19 and 25 October 2017.

Tosh Lodge is a service which provides accommodation and personal care for up to five people who are living with mental health conditions. There was one person living at the service when we inspected. who was also living with long term health conditions such as epilepsy.

This service is not required to have a registered manager in post. The provider had registered with the Care Quality Commission to manage the service and is therefore a 'registered person'. 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.

Tosh Lodge was last inspected in April 2017 when the service was rated inadequate in the safe, effective, caring and well-led domains and requires improvement in responsive. The service was placed into special measures. We found breaches of regulation relating to protecting people from abuse, management of risks to people and the environment, a lack of person centred care, care plans lacking detail and a lack of understanding about people's capacity to make decisions. Other breaches related to issues with staff recruitment and training, a lack of oversight of the service and not informing the Care Quality Commission of notifiable incidents.

At this inspection there were continued breaches of regulation and little progress had been made to improve the care and support people received. People continued to be at risk of harm due to a failure to treat people with dignity and respect. Although some staff treated people kindly, people were not always protected from abuse and were spoken to in a derogatory way. Plans to manage risks to people did not give enough detail and placed restrictions on people. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

When people became unwell they were not supported to access health care treatment promptly resulting in people being in pain for periods of time with no access to pain relief. Staff did not have guidance about how to support people with long term health conditions. People were not supported to be independent and there was a culture of doing for people, rather than with them. People's care plans contained contradictory information and lacked detail about how people liked to be supported and what they could do for themselves. People had limited access to activities and records showed they had long periods of time with no meaningful activity.

Staff were completing some checks relating to the environmental risks. However, water temperatures were not being checked regularly and were found to still be too high. Checks to the fire systems were completed and personal emergency evacuation plans were in place. People were supported by staff who had been recruited safely and who had received additional training. However, there was a lack or training and

understanding about how to support people when they were distressed or agitated and staff had not attended fire safety training which was highlighted at the last inspection as a shortfall. Although there were enough staff on the day of the inspection the service did not employ enough staff to meet people's needs in the event of illness or annual leave.

People told us they enjoyed their food, but that they had limited choice in what they could have to eat. People were not involved in preparing their meals. People's medicines were managed safely by trained staff. The provider told us they had received no complaints since the last inspection. People had been asked to given feedback on their support via a questionnaire which they were supported to complete by staff. The provider told us no notifiable incidents had occurred since the last inspection. The provider had not completed regular audits to identify areas for improvement. There was continued evidence of restrictive practices and the provider was not always knowledgeable about the guidance they should follow or their responsibilities as a registered person. The provider had not displayed the services rating as required by regulation.

We found a number of continued breaches 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

People were not protected from the risk of abuse.

Risks to people and the environment were not managed appropriately and action had not been taken to address risk identified at a previous inspection.

Staff had been recruited safely. However, there were not enough staff employed by the service to ensure people's support needs could be met.

People's medicines were managed safely. However, they did not always have access to pain relief when required.

Is the service effective?

Inadequate

The service was not effective.

People did not always have access to health professionals promptly and staff did not have guidance about how to support people's long term health conditions.

People were not supported to make decisions in the least restrictive way and staff had a limited understanding of the Mental Capacity Act (2005.)

Staff training had improved and they were offered regular supervisions. However, more training was required in relation to supporting people whose behaviours could challenge and fire safety.

People told us they enjoyed their food. However, they had limited choice about what they ate and were not involved in preparing their meals.

Is the service caring?

Inadequate

The service was not caring.

Although some staff treated people kindly, at times people were

spoken to in a derogatory way.

People were not encouraged to be involved in planning their care and support or to be as independent as possible.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans were not person centred and contained contradictory information. They lacked guidance for staff around people's preferences and what they could do for themselves.

Although people took part in some activities, there were long periods of time when no meaningful activity was offered to them.

The service had not received any complaints since the last inspection.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not have an open and inclusive culture.

The provider showed a lack of understanding of legislation and their responsibilities.

Although people who used the service were asked their views, no learning was evidenced. Audits to identify issues and improve the service had not been completed.

The provider had failed to display their rating as required by law.

Tosh Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 25 October 2017 and was unannounced. The inspection was carried out by two inspectors.

Before our inspection we looked at records that were sent to us by the provider and the local authority to inform us of significant changes and events. We also reviewed our previous inspection report, and the Provider Information Return (PIR) that the provider had completed. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection we spoke with people living at the service. We spoke with the provider and one member of care staff. We looked at one person's care plan and the associated risk assessments and guidance. We looked at a range of other records including one staff recruitment file, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

Inadequate

Is the service safe?

Our findings

The service was not safe. At the last inspection there were issues relating to how risks to people and the environment were managed. At this inspection these issues remained.

Some risks to people had been assessed but the plans in place to guide staff how to minimise the impact or occurrence of harm did not contain the information required. For some areas of risk no risk assessments were in place. People were not involved in managing their own risks or developing risk assessments. For example, people told us the best way for staff to support them to calm down was to ask them to spend some time in the garden, as it was their favourite place. This was not mentioned in their risk assessment which meant there was a risk they would not be supported to calm appropriately. The risk assessment also contained contradictory information about the use of physical restraint, stating initially that it must not be used, followed by a statement that if restraint was used it must be justified and done in a way which respected the person's human rights. Staff had not completed any training in relation to physical interventions. Although the provider told us they had never used physical interventions with people. There was a risk physical interventions may be used inappropriately and by untrained staff.

There were no risk assessments in place related to the person's long term health conditions such as epilepsy or previous heart conditions. Staff did not have guidance about signs to look for if the person's health conditions were to deteriorate or correct information to share with health professionals should the need arise. There was a risk that people would not receive the support they needed with these health conditions. When we spoke to the provider about this they told us that the person had not shown signs of either of those conditions whilst living at the service so they were not a risk. One person's risk assessment stated they were at risk of non-compliance with their medicines, there was no capacity assessment related to this and no guidance for staff about what to do if the person refused their medicines.

At our previous inspection the provider had not carried out all the necessary checks to make sure people lived in a safe environment and that equipment was safe to use. Water temperatures throughout the service had not been regularly measured to make sure they were within safe limits. There was no adequate thermometer available to check the temperatures.

Since our last inspection the provider had regularly been taking hot water temperatures. Since 17 June 2017 hot water temperatures at the service had been recorded as being 47C or above. During the inspection a person told us that their bath had been, "Red hot, it almost burnt me." We felt the hot water in the downstairs toilet and the upstairs bathroom, and it felt hot to the touch.

The provider tested the hot water temperatures and they were 53.4C. The provider told us that they believed safe hot water temperatures were between 50 and 60C. However, guidance from the Health and Safety executive states that hot water temperatures should not exceed 44C in health and social care settings. The provider's own risk assessment stated that hot water temperatures should not exceed 43C. People were vulnerable and living with mental health needs and acquired brain injuries. There was a risk they may scald or burn themselves on water that was an unsafe temperature.

Fire systems had been checked though the provider told us some records were not available. At the last inspection we raised a concern that staff had not undertaken training in fire safety. This had not been resolved and no training had been provided for staff. People did have personal emergency evacuation plans in place which gave staff guidance about the support they would need to leave the service in case of an emergency such as a fire.

Failure to appropriately assess and mitigate risks and to provide staff with the training required to keep people safe, is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection there had been a breach of regulation related to keeping people safe from abuse. Referrals had not been made to the local authority when required and incident forms had not been completed. There had been no incidents which required reporting to the local authority since the last inspection. However, incident forms still were not being completed and therefore were not being analysed for learning. There were two incidents from May and June 2017, recorded in the service's complaints book which had not been recorded on an incident form. These involved an argument between people and a person becoming upset and attempting to hit out at staff. No action had been taken to look at the cause of these incidents or to plan how to minimise the risk of reoccurrence. The provider told us these incidents may have been recorded in an incident book she had archived.

People were at risk of psychological harm due to how they were spoken to. Records showed that one person had been reprimanded about their behaviour and had been told they were 'manipulative' and 'threatening.' They were also told their behaviour could be the cause of other people's unhappiness and problems. There was a risk this could impact on the person's mental health and emotional well-being. Staff had received training in safeguarding people and told us they would report any concerns. However, they had not recognised the treatment of people as possible abuse or reported to the appropriate authority.

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

At the previous inspection appropriate checks to ensure staff were suitable to support people had not always been carried out. This had improved, in the staff file we reviewed we saw evidence of checks being completed including references and Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.
There were enough staff on duty to meet the needs of people. However, the provider had not employed enough staff to provide support in the case of annual leave or staff sickness. This also led to staff working for long periods of time without a break.

People's medicines were managed safely by staff who had been trained. Medication administration records had been completed fully and accurately. On person told us, "They are in there" (pointing to where the medicines were stored) "I have them in the morning and at night. The staff put them on the kitchen side and I take them." People did not have access to any pain relief. We asked the provider about this they told us that people had never needed any pain relief whilst living at the service. They told us if people needed pain relief they would contact the GP.

Inadequate

Is the service effective?

Our findings

People told us that they liked the staff member who was supporting them. There continued to be a number of shortfalls which had not been addressed since the previous inspection.

At the last inspection people did not always receive the support they needed with their health care needs. This continued to be the case at this inspection. When we arrived on the second day of the inspection one person told us they were in pain. They were visibly showing signs of discomfort and holding onto their arm. We asked the person if they had seen a doctor or had any pain relief. The person told us that the provider had spoken to the GP and was getting some pain killers for them. We asked staff when the pain relief was due to arrive. They clarified that the GP had sent the prescription to the local pharmacy who would be delivering the medicines. When we left the service at 1800 the medicines had still not arrived and the person continued to show signs of distress and pain. The pain was in the person's left shoulder and given their history of heart problems there was a risk that they could have a serious health issue. One person had had a reduction in their mobility, no referral had been made to investigate this or seek advice from health professionals about ways to improve support for the person.

People's health care plans did not give full details of their previous health conditions or guidance to staff about the support they may need to manage those conditions. One person's assessment, completed by the local authority in 2008 stated they had epilepsy. There was no information in their care plan regarding this potentially unstable condition. The provider told us the person had never had a seizure since they had been living at the service. They had not spoken with the person's GP to confirm their epilepsy diagnosis. There was no guidance about what staff should do if the person were to have a seizure. People were living with the results of an acquired brain injury; however, there was no information for staff about the impact this may have on people. Care plans did give details of signs to look for to identify if people were having a relapse in their mental health. However, guidance given for staff about how to support this lacked detail and was generic.

The failure to meet people's needs is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection, the service did not always meet with the principles of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). This was because some restrictions were in place without following proper process and people's capacity had not been assessed.

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 so that they can receive care and treatment when it 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).

Only one capacity assessment had been carried out, there were no capacity assessments in place relating to people making other decisions about their care and support. Such as managing their medicines, access to knives or leaving the service unsupported.

At our previous inspection we found that there were unnecessary restrictions on people's lives and they were unable to access certain cupboards in the kitchen. At this inspection we found that the kettle was not freely available if people wanted a hot drink. One person had tried to boil the kettle without any water in it, and the provider had locked it in the utility room. We asked the provider if they believed this to be the least restrictive way of reducing this risk, and they told us, "Yes." There was always staff available at the service, to assist the person and ensure they did not put the kettle on without water in. The person's care plan also showed they had restricted access to knives and the cooker due to historical behaviours which could challenge, despite the provider telling us there had been no issues related to this in many years. Records supported the information given by the provider about no recent issues with the person's behaviour.

People told us they enjoyed their food and often went out to eat. When we asked them how they chose what they ate in the service they told us the menu had been decided in a meeting. The menu was based on the choices of all of the people who had previously lived at the service and had not been updated to reflect the preferences of the one person remaining. We asked people if they were involved in preparing their meals. One person said, "No. I would like to though. I worked at a theatre in London in the kitchen." The provider told us they tried to encourage people to be involved in household tasks but they refused. We asked people about if they could help themselves to food or a snack if they were hungry and they told us, "I have to ask the boss." The provider told us this was not true and that this person called everyone boss. The kitchen cupboards were not locked but people were reluctant to access them without permission.

Staff had regular supervisions with the provider to discuss their performance, any concerns and any training needs. At the previous inspection shortfalls were identified in staff training and competency. Some improvements had been made and staff had attended training courses relating to epilepsy and diabetes. Staff showed a good understanding of these subjects. However, staff still had not undertaken training in fire safety and had minimal training in supporting people whose behaviour could challenge. The provider told us that as part of the staff member's induction they spoke to them about a variety of issues relating to behaviours which can challenge. There was no competency assessment around this and staff had not completed training in physical interventions despite this being identified as a possible need in people's care plans.

Inadequate

Is the service caring?

Our findings

Although the staff on duty during the inspection treated people kindly and in a caring way, there were continued issues identified at the last inspection about how people were treated.

At the last inspection, people were having restrictions placed on them which did not respect their human rights and resulted in them being treated in an undignified way. At this inspection this continued to be the case, although signs prohibiting people from accessing food cupboards had been removed, people still told us they were unable to access them freely. When we raised this with the provider they told us, "They are lying, I don't know why you are listening to them, they are only a service user." People's daily notes showed that people had been spoken to in a derogatory way.

People told us they had read their care plan and signed it. However, care plans were not written using accessible language and showed little evidence of the involvement of people. There was no information about how people could become more independent or develop new skills. We spoke with people about how they were involved in looking after their home. They told us, "I tidy my own room and make my bed, but the staff do everything else. The 'boss' (provider) does the food shopping every week. The staff even put my cereal in the bowl for me this morning." People's daily notes supported what the person had said and evidenced a culture of doing for people rather than with them. The provider told us this was not accurate and staff had recorded it incorrectly. On the second day of the inspection we saw that daily notes showed that people had been supported to prepare meals. However, people told us this had not changed and we observed staff preparing a meal for people with no involvement from them.

One person told us that they used to attend a certain type church when they lived in another area. When we asked if they were supported to visit the local church they told us, "Staff don't believe in it so I can't go." There was no reference to their religious beliefs in their care plan.

The failure to treat people with dignity and respect and to support independence and autonomy is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff knew people well and communicated with them in a way they understood. One person was planning a trip out, staff prompted the person counting down the time until they were due to leave and asking if they needed a coat. However, records showed staff did not always use their knowledge of people to anticipate their needs. For example, one incident record showed that two people had begun arguing, staff did not attempt to distract people and did not take into account that one person was distressed as they had recently had a relative pass away. Staff only noted this when the person told them after the incident. There was no record of any additional support offered to the person to deal with their bereavement.

People told us they could have visitors when they liked and that their family had been to visit them. However, the provider had had the phone line to the service disconnected; as a result all communication between people and their relatives or friends was by use of the provider's mobile phone. This limited the opportunity for people to have contact with their loved ones when the provider was not at the service and

their opportunity for privacy when they were available.

Inadequate

Is the service responsive?

Our findings

People told us they did take part in local clubs and went to the library but also stated they got bored as there was no one to talk to.

Shortfalls in people's care plans found at the last inspection had not been addressed. People's care plans were not person centred and lacked detail. Although there were some details of people's likes and dislikes these were scant and primarily related to one or two foods. One person told us they didn't like spicy food and loved a take away from the local kebab shop but this was not recorded in their care plan. There was very limited detail about people's life history aside from a focus on the progress of their mental health condition.

People we spoke to told us about their childhood and their family, their work history and places they had lived. However none of this information was reflected in their care plans. When we asked the provider about this they told us that some people would tell stories that were untrue and would make up things, which is why it was not recorded. The lack of information in people's care plans placed people at risk of not having the support they needed and staff at risk of being unaware when people were being truthful. This could lead to staff being unaware of a deterioration of people's mental health and possibly challenging people about information which was true.

People's goals were generic such as refraining from violence and aggression. They did not provide guidance as to how people could work towards achieving them or how staff could support them to do so. As a result there was no opportunity for people to take small steps towards a goal or celebrate achievements. People's care plans stated that they were working towards becoming more independent in managing their medicines. However, people told us that staff gave them their medicines and there was no guidance about how people would be supported to develop the skills to take more control of manging their medicines.

People attended a local club on a regular basis and told us they enjoyed it, they said, "I go twice a week and I like it. I get to see my friends." They also told us they enjoyed going to the local library (where they went on the day of the inspection) where they had lunch. However daily records showed that on some days people's only activity had been to walk to the local cash point. They told us they got bored as there was no one to talk to.
People's care needs were not regularly reviewed and no changes were made to their support as a result of a change in need. People's immediate care needs were not responded to. For example, when people were unwell assistance was not sought quickly and at times their concerns were dismissed. One person was told, "Oh well you weren't in pain yesterday were you." Their daily notes showed they had complained of pain the previous day.
The failure to provide person-centred care planning and support is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider told us that there had been no complaints since the previous inspection. There was a complaints policy on the wall but this was not in an accessible format and did not give details of who the

person could contact outside the service. Records showed that when people raised concerns to the provider they were not addressed; rather people were, 'told off' or their concerns were dismissed. When asked about this the provider told us, "People lie."
The provider had failed to operate an effective complaints procedure and failed to respond to people's complaints appropriately. This is a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

At the last inspection the leadership and management of the service was inadequate and placed people at risk of harm. This continued to be the case at this inspection.

The provider had failed to ensure that a there was a positive, person centred culture at the service which was open, inclusive and empowering. They had also provider failed to ensure they demonstrated good management and leadership, and failed to ensure people received high quality care. This had a major impact on people. People told us there continued to be restrictive practices, and that they had to ask before getting food or drinks. This was supported as one person's care plan stated they were not allowed access to the kettle and must ask staff if they wanted to use it to make a hot drink. The provider stated this was the case but that they felt it was the least restrictive option to keep the person safe. However, no alternative measures had been considered. The provider also told us that the person who had told us they had to ask for things was lying to us. Staff continued to work in line with the provider's example and did not appear to feel comfortable to challenge the provider.

People's care plans had been reviewed every six months but learning from the last inspection had not been taken on board. Care plans remained generic and lacked detail. We found that incidents had been recorded in the complaints book, the provider had crossed out parts of what staff had recorded and written over it. For example, one report stated that a person had hit a member of staff in the face. The provider had crossed this out and written the person touched the staff members face. The incidents were not recorded in the incident records book. There was a risk the information about these incidents would not be taken into account when planning people's care or managing risks related to their behaviour. The provider could not find some requested documents such as additional incident books, stating they may have been 'put away somewhere.' They also took some time to find other documents such as fire safety records, there was a risk that staff would not have access to the information they needed to meet people's needs.

At the previous inspection it was identified that water temperatures were too high putting people at risk of scalding. At this inspection the continued to be too high, when we asked staff about the recording of temperatures we were told they were not measured unless there was an issue. The provider then told us that they took the temperatures on a regular basis. Temperatures were found to consistently be above safe levels, when we raised this with the provider they stated the temperatures were not too high. The provider had failed to follow nationally recognised guidance and safety standards.

Risk assessments relating to people had been updated. However, they continued to lack detail and did not provide staff with the guidance they needed to minimise risks. Some risk assessments were contradictory, as a result there was a risk staff would be unsure of the safest way to support people.

The provider had had the phone line to the service disconnected. There was a risk that people and staff could not call for assistance in an emergency or receive calls from health professionals if required.

The failure to assess, monitor and mitigate risk and to maintain accurate records is a continued breach of

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

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The rating was not displayed at the service.

The failure to display the service's rating is a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) 2014.
There continued to be issues with the auditing systems at the service. The provider was not carrying out regular audits of the service. Audits and reviews which had been completed had not highlighted issues such as the continued lack of detail in care plans and risk assessments or the high water temperatures.

The provider was reluctant to engage with CQC inspectors and refused to provide copies of documentation when requested.

At the last inspection we found that the provider had not been informing the Care Quality Commission (CQC) about serious incidents, which they are required to do by law. No notifications had been received since the last inspection; however we found no records relating to incidents which should have been reported.

People were supported by staff to complete a survey asking for their views about the service and the support they received. They told us, "The staff read it to me then I ticked my answer and signed it." No feedback had been sought from other stakeholders since the last inspection. In the surveys people had responded that they were happy with everything and raised no issues.

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 failure to meet people's needs

The enforcement action we took:

Service has already had a NOD issued to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure to treat people with dignity and respect and to support independence and autonomy.

The enforcement action we took:

Service has already had a NOD issued to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to appropriately assess and mitigate risks and to provide staff with the training required to keep people safe.

The enforcement action we took:

Service has already had a NOD issued to cancel registration.

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 People were not protected from abuse.

The enforcement action we took:

Service has already had a NOD issued to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The failure to maintain accurate records & failure to assess, monitor and mitigate risk.

The enforcement action we took:

Service has already had a NOD issued to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments Failure to display the rating

The enforcement action we took:

Service has already had a NOD to cancel the registration.