Broadoak Group of Care Homes

South Collingham Hall

Inspection report

Newark Road
Collingham
Newark
Nottinghamshire
NG23 7LE

Date of inspection visit:
11 March 2019

Date of publication:
01 November 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: South Collingham Hall 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. South Collingham Hall provides personal and nursing care for up to 33 people. We inspected the service on the 11 march 2019, at the time of the inspection 23 people were using the service.

People's experience of using this service:
Although the risks to people's safety had been identified, measures to mitigate these were not always in place. The assessments of people's needs were not always current and the treatment they received was not always in line with their assessments. Some areas of the environment posed a risk to people's safety, this included the risk of infection. People did not always feel there were adequate numbers of staff available to support them. There was a lack of processes in place to learn from incidents and accidents at the service. Staff had not always received the appropriate training for their roles. People were not always supported with their nutritional needs; some people did not receive diets appropriate to their needs.
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.

People had built some positive relationships with staff; however, people were not always supported to receive individualised and personalised care in a timely way. Furthermore, people's privacy and dignity was not always well supported. There was a lack of social stimulation for people at the service. The registered manager had not kept a record of complaints made to the service, although people told us their complaints were addressed.

There was a lack of leadership and over sight at the service and the quality monitoring systems did not highlight when there were concerns or issues about people's care or the environment they lived in.
Rating at last inspection: Requires Improvement.

Why we inspected: This was a planned inspection based on the rating at the last inspection. sufficient improvements had not been made since our last inspection and the rating has worsened to a rating of Inadequate. This is the fifth consecutive time this service has not received a rating of Good.

Enforcement: 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.

Follow up: The service has now been placed in special measures. This means we will work with the provider to improve the service and work with partner agencies to monitor the service.
We will keep the service under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, we will inspect it again within six months.
We expect that providers found to have been providing inadequate care should have made significant

improvements within this timeframe.

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

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 safe.

Details are in our Safe findings below.

Inadequate

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

South Collingham Hall

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team: The inspection was carried out by two inspectors, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type; South Collingham Hall is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The service had a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This 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: We reviewed information we had about the service prior to our inspection. This included previous inspection reports, details about incidents the provider must notify us about, such as abuse and accidents. We spoke with the local authority quality monitoring team who work with the service.
During the inspection we spoke with 11 people at the service and three relatives to ask about their experience of the care provided. We also spoke with a health professional who was visiting the service. 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 spoke with four members of care staff, the activities co-ordinator, the cook, and a housekeeper. We also spoke with the deputy manager, and registered manager.
We reviewed a range of records. This included five care records, medication records and four staff files. We also looked at the training matrix, audits, accident records and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

●Although people's care plans had identified measures to mitigate the risks to their safety the measures were not always in place. One person's risk assessment showed they had been assessed as requiring a pressure relieving air mattress on their bed to reduce the risk of pressure ulcers.

●We checked the person's bed and found the air mattress was not switched on. The mattress needed to be on at all times to maintain the required pressure relieving settings assessed for the person. This meant the person was not protected from the risk of developing pressure ulcers, as the identified measures to reduce the risks were not followed by staff.

●There was a lack of robust protocols and policies in place to support staff with different aspects of care. One person had fallen and sustained a head injury a few days prior to our visit. There was a lack of records in place to show how the person had been monitored following this injury. The head injury protocol in place did not give clear guidance to support staff in how to manage the person following their injury. We asked the registered manager to provide us with a more robust protocol to assure ourselves staff received clear guidance to support them in the future.

● People had been assessed as requiring walking aids to assist them, however these were not always in place. During mealtimes two people's aids were place outside the dining room while they had lunch. We were told this was due to the lack of space in the dining room for the aids. We saw one person did attempt to get up and walk without the aid. Staff were required to go and support the person. However, it was possible to arrange the room to allow the aids to be kept with each person and the current practice put people at increased risk of falls.

●We saw one example of poor moving and handling practices during our inspection, and a further example of staff not following the guidance in a person's care plan when using moving and handling equipment. We highlighted this to the registered manager who told us they would address this.

●Some areas of the environment posed a risk to people's safety. A dining table in use, was in poor condition and was very wobbly. There was a possibility of it collapsing if someone fell heavily against it and this increase the risk of injury to both the person who fell against it and whoever was sitting at the table.

●One bathroom we looked at had a toilet which had a yellow bag taped over the top, we were told the toilet was out of use, but there was no other signage to show the toilet and bathroom should not be used. A further bathroom had some water on the floor around the toilet and the bath panel was in poor repair. We were told there had been a leak identified prior to the weekend and was due to be addressed by the maintenance team. However, there was no signage to alert staff to the leak and we found no evidence that the leak had been reported.

●Window opening restrictors to prevent people from fully opening and either climbing or falling out of the window had not been consistently implemented. Some windows did not have window restrictors fitted so the risk to people's safety had not been fully mitigated. The bedrooms we viewed had wardrobes which were not attached/fitted to the wall. This posed a risk to people's safety.

●The back-entrance door to the service was used frequently by staff to allow access to the laundry room. The door was not locked and had an alarm which sounded, to alert staff when it was opened. However, during our inspection, we frequently heard the alarm and saw staff did not respond immediately when the alarm sounded as they assumed staff were accessing the laundry room. This posed a risk that people could access the outside of the premises without staff being immediately aware they had left the premises.

Preventing and controlling infection

●People were not always protected from the risks of infection as some areas of the building and some equipment was not free from dirt and debris, we found one piece of moving and handling equipment in a bathroom which had visible signs of dirt on it. Some raised toilet seats were dirty, and some equipment was in poor condition that hindered cleaning.

●Although staff told us they understood how control the spread of infection by using appropriate equipment and following safe practices when undertaking tasks, on the day of the inspection some staff did not always follow these safe practices. When dealing with hazardous waste they did not wear appropriate personal protective equipment (PPE). There was a lack of waste paper bins in most bedrooms and en-suite bathrooms at the service.

●There was a lack of hand washing posters and although there was some personal protective equipment (PPE) available of staff there was a lack of identified holders for the PPE in some areas and gloves and aprons were left on window sills.

●We viewed some environmental audits that had been carried out on the day of our visit and found the audits had recorded areas as been clean, but when we viewed the areas we found they were not clean. We raised this with the registered manager who told us they would address the issues. However, this showed a lack of robust monitoring of the cleaning processes at the service.

The above issues meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People did not always feel there were adequate numbers of staff available to support them. One person said, "They seem to know what they are doing, but sometimes there does seem to be a shortage of staff around."

●Feedback from staff was also mixed. One member of staff told us short notice sickness was not always covered. The staff rosters we viewed showed that there were some days when sickness had not been covered. The deputy manager told us they did always try to cover short notice sickness. However, it was clear from the roster the staff levels did not always meet the established needs of people at the service.

●The registered manager told us they regularly reviewed staffing levels to ensure the needs of people were met. They told us the numbers of people using the service had been reduced recently and this had impacted on the numbers of staff required. But they told us should the numbers of people who used the service, or the needs of people already using the service increase, they would ensure the numbers of staff matched the needs of people in their care.

●Safe recruitment practices were undertaken to ensure people were supported by suitable staff. Checks on previous employment, references and disclosure and barring service (DBS) checks had been carried out prior to employing staff. The DBS checks allow prospective employers to check if potential staff have criminal convictions that may affect their suitability to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse

● Although staff we spoke with told us they understood how to protect people from abuse and had received training in safeguarding issues, including how to report issues of concern. We were told by a member of staff

of one area of concern, however they had not raised their concerns with the registered manager.
●We raised the concern with the registered manager and following the inspection, with the regional manager, and asked them to investigate the concern and ensure the local safeguarding teams were aware of their actions. The regional manager fed back to us they had addressed the issue and followed our requests. However, this lack of action by the member of staff in raising their concerns to the registered manager did not assure us that staff were raising safeguarding issues to either the registered manager or the local safeguarding teams in a timely way.

Learning lessons when things go wrong
●People were not protected from the risk of incidents occurring as there was a lack of processes in place to support staff learn from incidents and accidents at the service. Although we saw there was a regular individual supervision programme in place for staff, there was a lack of documented handovers or staff meetings to show discussions had been undertaken when incidents had occurred.

Using medicines safely
● People were provided with safe care in relation to the administration of their medicines. We saw safe practices undertaken, appropriate and safe record keeping in place. Medicines were kept securely and at the correct temperature and staff received appropriate training in the safe handling of medicines.
● When people needed to have medicines administered covertly, assessments had been undertaken with the support of the appropriate health professionals. There was clear information for staff on how these medicines should be given.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●People's needs were assessed using nationally recognised tools, such as the waterlow scoring tools that assesses people's skin care needs in relation to the possibility of pressure damage. ●However, we saw these tools were not always used effectively. Staff had identified that one person had increased needs in relation to possible pressure damage. Staff had applied pressure relieving equipment that had not been assessed as suitable for that person.
●We were told this was on the advice of a health professional, but there was no record of this advice and there was confusion among staff as to when the pressure relieving aids had been used. This shows the staff were not using the assessment tools to ensure people received the most appropriate and safe care for their needs.

Staff support: induction, training, skills and experience
● People we spoke with felt staff had the skills to support them.
●However, the information we received about staff training showed their staff training was not always up to date. For example, one member of staff who had started with the service in three months prior to our inspection had not completed a number of aspects of training such as moving and handling, safeguarding adults, health and safety and infection prevention.
●We were told the person had worked in the care sector prior to starting at the service, however, there was no information to show when they had last received the training on these aspects of care. This meant the registered manager could not be sure that the staff member's knowledge was current and up to date. This put people at risk of receiving unsafe care. Following our inspection, the registered manager told us they were addressing this short fall with the staff member.

Supporting people to eat and drink enough to maintain a balanced diet
●People were not always supported with their nutritional needs.
●One person required a high fibre diet, their care plan stated they should be offered high fibre breakfast cereals. On the day of our visit the person was eating a cereal which was not high in fibre. Their care plan recorded the person had short term memory loss and needed reminding to eat a high fibre diet.
●People were not always offered regular drinks and for the first part of the morning we noted there were no drinks available in the lounge areas for people.
●However, we did see some areas of good practice. When it was identified a person was losing weight they were referred to the most appropriate health professional for advice on their diet. There was also good information on people's dietary needs in their care plans and in the kitchen.
●The cook had a good knowledge of people's dietary needs and told us they worked closely with the care

staff to support people if they were losing weight.
● People also told us they thought the food at the service was good and their preferences were catered for.

Adapting service, design, decoration to meet people's needs
●People lived in a service that had been adapted to meet their needs, however the building was an old building and there were areas of the service that needed improvement. Some corridor floors at the service were uneven, this increased the risk of falls for people at the service. A glass panel was missing from a downstairs toilet. An A4 piece of paper was stuck in its place to cover the hole. Metal from one radiator was sticking out of the wall in the main foyer at ankle level.
●The outside area was not enclosed which meant people who may have short term memory loss would not be safe to access the outside areas without staff supervision. The front entrance ramp was approximately an inch lower than the step to the building, this was a trip hazard for people entering the building.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. There was a lack of evidence to show the provider was working within the principles of the MCA.
●Documentation showing up to date authorisations of DoL's was not available and the registered manager had not informed us of the DoLS authorisations in place for the people in their care. The registered manager was unable to show us that people's DoLS authorisations were still current and that any conditions placed on the DoLS had been met. Following our inspection, the registered manager sent us information to show the DoLS authorisations were in place.
●However, there was Information in people's care plans to show examples of how people had been supported to make decisions about their care. When it was thought they lack capacity assessments had been undertaken to establish what support people needed for individual decisions. Relatives and health professionals had been involved in this process and decisions made and been the least restrictive options.

Staff working with other agencies to provide consistent, effective, timely care, supporting people to live healthier lives, access healthcare services and support
●People were supported to access health professionals when they needed them.
●People had regular visits from a chiropodist, and an optician attended the service on a yearly basis to support people with any visual needs they had.
●People and their relatives told us staff were quick to deal with any acute health care needs, one relative said, "They (staff) are always on the ball if they think [name] needs to see a Doctor." During our visit staff called out a person's GP as staff were concerned about them.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

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

●People told us they were not always supported in a timely way. We saw examples of people being left for long periods of time in wheelchairs in the dining room when they had finished their meal.

●People were not always supported in an individualised and personal way. During the first part of the morning people were sitting in the lounge with no drinks available to them. One person asked a staff member for a hot drink. They were told a hot drinks trolley would be coming round soon. There was no attempt to get the person a drink sooner.

● People were not always supported to access information to support their daily choices. For example, meal choices were written on a white menu board in the dining room. The print was small with no pictorial references to the foods on offer that day. This meant people who had visual or comprehension difficulties were not able to see what meal choices were available to them that day.

●When we first arrived at the service the board showing the date and day of the week had not been changed from the previous day. This was not changed until the later part of the morning. As a result, several people we spoke with were confused about which day it was.

●The feedback from people about staff attitude towards them was mixed. The majority of people told us most staff were kind and caring, however we were told at times some members of staff could lack empathy when providing care, one person told us this made them uncomfortable. We fed this information back to the registered manager who told us they would address this with staff.

●We saw some positive interactions between staff and people when they were providing care. However, the interactions we observed were task orientated and people told us staff did not have time to sit and chat with them.

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

●There was a lack of evidence in people's care plans to show they or their relatives had been involved in reviewing their care. One person we spoke with did not know what a care plan was. When we explained they told us they had not been involved in their care planning.

●There was information in people's care plans about their preferences in relation to the gender of staff they wanted to support them when they received personal care. However, staff we spoke with were unaware of these preferences. This posed the risk that people's choices and preferences would not be adhered to.

●People had access to independent advocates. Whilst we did not see any posters or information for people about advocacy services, we were told that some people were using the services of an independent mental capacity advocate (IMCA). An IMCA is a new type of statutory advocacy introduced by the Mental Capacity Act 2005. The Act gives some people who lack capacity a right to receive support from an IMCA.

Respecting and promoting people's privacy, dignity and independence

● People's dignity was not always maintained, we saw one person who had been left with a hoist sling in place while they sat in their chair. This left their clothes rumpled up and parts of their body exposed. Staff made no attempt to address this.

●People told us that staff did knock on doors before entering their rooms and ensure curtains and doors were closed when providing personal care.

●There were examples of people being supported to maintain their independence. One person enjoyed going out for a walk throughout the day on their own, and we saw staff facilitating this.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
●The information in people's care plans was detailed and clear, however we found staff were not always following the guidance in people's care plans.
● People's care records showed if they required their food and fluid intake monitored and recorded. The fluid and food records we viewed after the afternoon meal on the day of our inspection had not been completed for that day. Other food and fluid chart for previous days did not give sufficient detail in terms of amounts people had eaten and drunk to show adequate monitoring was being undertaken. This meant staff were not using the records to effectively monitor people's nutritional needs.
●There was a lack of communication around the changes to people's daily needs. There was a lack of daily handover records for staff to refer to when they wanted to check any changes to people's care.
●This impacted on the care people received. For example, we saw one person had some pressure relieving equipment in place but there was a lack of information in their care records to show who had prescribed this equipment. Staff could not give consistent information as to when the person had started to use the equipment and who had assessed and prescribed it. This meant the person may have been using equipment that was not suitable for their needs. We discussed this with the registered manager who told us they would address this.
●There was a lack of social activities to keep people stimulated and prevent isolation. One person when asked what they did during the day said, "Not a lot, but I do like to join in things."
●The provider employed an activities coordinator five days a week for two and a half hours a day. While we saw they were able to engage people in the communal areas during this time, they lacked the time to spend time with people who spent time in their rooms. This meant people often felt isolated and bored.
●There was a lack of accessible information for people at the service. Signage at the service was poor. The doors to people's rooms were uniformed and did not support people to find their rooms. The only attempt made to help one person find their room was their first name handwritten in marker pen on their door.

Improving care quality in response to complaints or concerns
●There was a complaints policy displayed on the office window in the entrance hall of the service. However, the position and font size of the policy did not make it easy for people to see.
●People and relatives knew who they should speak to if they had any issues or complaints and when they did, these had been dealt with by the registered manager. However, the issues they had discussed with us had not been recorded in the complaints file the registered manager kept. The registered manager told us they did not record the issues as complaints, this meant they were not reviewing issues of concern to establish trends, discuss with staff and make improvements for the future.

End of life care and support
● Information around people's end of life wishes were recorded in their care plans. The registered manager

told us they made time to discuss this aspect of care with either the person or their relatives at the appropriate time. There was evidence of discussion around end of life preferences in the care plans we viewed.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- Prior to this inspection South Collingham Hall has been inspected five times since April 2016. Following four of the inspections the provider was in breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.
- Although at our last inspection there had been improvements in the quality monitoring processes at the service, and the provider was not in breach of this regulation, we found there were still further improvement required.
- At this inspection the registered manager had failed to sustain the improvements made at the last inspection and had not made any further improvements to the quality monitoring of the service.
- The lack of robust environmental audits resulted in us finding concerns with the maintenance of the building. This included lack of radiator covers on some radiators, lack of window restrictors on some windows, damage to doors and walls. These issues had not been identified by the providers quality monitoring processes.
- Environmental audits we viewed dated as being carried out on the day of our inspection did not highlight the issues around cleanliness that we found when we walked around the service. The audits had been signed with the registered manager initials, however we established the registered manager had not carried out the audits, another member of staff had completed the audits and added the registered manager's initials.
- We discussed these failings with the registered manager who told us they had discussed concerns around cleanliness with staff the week prior to our visit. However, there was no record of the conversation and the audits for that week did not highlight that concerns with cleanliness had been recorded. The registered manager accepted these issues should have been recorded and monitored if improvements were to be made.
- The lack of regular monitoring of DoLS authorisations had also meant the registered manager could not be sure they were lawfully depriving people of their liberty.
- The lack of oversight of people's care impacted on a number of aspects of their needs. This included food and fluid management, and tissue viability, the lack of records in relation to staff handovers and staff meetings. This had resulted in confusion among staff in relation to changes to people's care needs and meant people did not always receive appropriate safe care.

The above issues impacted on the quality of care people received and meant the provider was again in

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

●There were concerns with the management of electronic data at the service, due to the lack of knowledge, skill and training of the registered manager. This impacted on confidentiality and the management of sensitive electronic data in all areas of the service.
●The registered manager had not fulfilled the requirement of their registration with the CQC to send notifications of events at the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.
● Although the care plans we viewed had detailed information around people's care. The guidance was not always consistent with the care people received. The lack of detailed handovers for staff and lack of oversight of the daily care provided for people had led to inconsistencies in their care. Examples of this are detailed elsewhere in this report.
● It is a legal requirement that a provider's latest CQC inspection is displayed at the home where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Continuous learning and improving care.
●There was a lack of engagement between the registered manager and people who used the service, their relatives and the staff at the service. There was a lack of resident and relative's meetings to discuss aspects of care.
●The quality assurance questionnaires which had been sent out to people in 2018 had not been analysed. The questionnaires we viewed were mostly positive but there had been a small number of negative comments in relation to personal care and the environment. There was no indication what had been done to address the comments raised.
●There was a lack of regular staff meetings and staff did not always feel they were listened to when they raised issues with the registered manager.
●There was a lack of systems in place to ensure continuous learning and improve the care people received.

Working in partnership with others
●Visiting health professionals, we spoke with told us the staff at the service worked with them to support people at the service.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not fulfilled the requirement of their registration with the CQC to send notifications of events at the service.

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 The risks to people's safety were not managed effectively

The enforcement action we took:

We issued a notice for positive conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance there was a lack of effective quality monitoring processes in place to ensure good oversight of the service

The enforcement action we took:

we issues a notice for positive conditions on the provider's registration