Parfen Limited

Sunnyside Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Sunnyside Residential Home is a care home providing personal and nursing care for up to 27 people over three floors. At the time of the inspection, 19 people were living at the home

People's experience of using this service and what we found
People were not always kept safe from the risk of harm. We identified at our last inspection in June 2021 appropriate steps had not been taken following a serious safeguarding incident. At this inspection some action had been taken, however, training to improve the managements' understanding of how to support the person involved in the incident had not been undertaken. Other safeguarding concerns were identified at this inspection. Feedback from a consultant involved with supporting the service and from staff raised concerns about a 'closed culture' at the home. Medicines were not managed safely, while we were unable to identify impact, continued gaps in medicine records were identified. People's dependency had not been assessed and staffing levels were not sufficient to meet people's needs. While some staff training had been arranged and undertaken since our last inspection, significant gaps remained; this included gaps in the management team's training, learning and development. Infection control practice had improved slightly but remained unsafe.

Audit and governance systems had not been developed since our last inspection and the registered manager acknowledged audits were not always completed. Staff reported feeling unsupported by the management team. The consultant contracted by the provider to work with the management team to improve compliance with regulations raised concerns regarding the registered manager's integrity, ability and motivation. We identified inconsistencies in people's records, including monitoring charts, risk assessments and care plans, this has continued to be unaddressed. The provider had failed to display their most recent rating on their website. The rating was displayed in the home but not was not accessible to visitors.

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 and in their best interests; the policies and systems in the service did not support this practice. The provider supported people who would need to be supported in accordance with 'Right Support, Right care, Right Culture' guidance. Their statement of purpose and registration had not been updated to reflect this.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 16 August 2021) and there were breaches of regulation. The provider did not complete an action plan after the last inspection to show what they would do and by when to improve; we monitored progress through regular meetings with the local authority. At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 6 March 2021. During this inspection the provider was unable to demonstrate that improvements have been made. The service continues to be rated as inadequate overall and in the key questions of Safe and Well-Led. This service remains in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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 COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

We have found evidence the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating. The overall rating for the service remains inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

Following our inspection in January 2021, we started enforcement proceedings against the provider and decision was made to cancel the providers registration. We have inspected the service on three occasions since then, including this inspection and found practice related to the safe and well-led key questions has consistently deteriorated.

We have identified breaches in relation to person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, good governance, staffing and the need to display performance assessments.

The provider withdrew their appeal against the notice of decision to cancel their registration.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Sunnyside Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, one medicines inspector and two Experts 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
Sunnyside Residential Home 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, both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Inspection activity started on 13 January and ended on 24 January 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We sought feedback from local authority colleagues and reviewed information we held about the service. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and nine relatives about their experience of the care provided. We spoke with 11 staff including the registered manager who is also registered as the nominated individual, the deputy manager, senior care and care workers and a consultant who had been contracted by the provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits and policies and procedures were reviewed. We made observations of care being provided to help us understand the experience of people who could not talk to us.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We looked at training records, health and safety certificates and additional policies. We sought regular feedback from the consultant working with the provider and from colleagues at the local authority involved in supporting the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure consistent and accurate records were in place. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Risks to people's physical, mental and emotional wellbeing were not always accurately assessed. We found records used to monitor and assess risk levels, including monitoring charts, risk assessments and care records were not always completed accurately or consistently.

The provider had failed to ensure consistent and accurate records were in place or used to identify learning and inform improvement. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● Measures to manage risk associated with people's care were not always detailed in risk assessments. Additionally, measures which had been identified were not always followed. For example, one person had been assessed as needing a pressure cushion to mitigate the risk of pressure sores and this had not been put in place for several months.
● Fire escapes were not all alarmed and were used by some residents to access outside areas to smoke. This meant there was a risk of people accessing these areas and sustaining an injury or leaving the premises, without staff being alerted. We asked the registered manager about this who said, "Fire escapes are not alarmed up yet, we had a quote but it's not booked in, (the director) said no not at the moment because of the financial situation."
● Several people had risk assessments which stated, whilst they were in communal areas, they should be monitored by staff. We made observations of the lounge and other communal areas throughout the inspection and found these areas were not always staffed to allow for the monitoring required.
● Building related safety certificates were not all in in place; for example, there was no Legionella Certificate or Gas Safety Certificate to evidence compliance with requirements. The consultant supporting the home stated they had followed this up with the registered manager and acknowledged these certificates were still not in place.

The provider had failed to ensure they had done all that was reasonably practicable to mitigate risks

associated with the provision of people's care. The provider had also failed to ensure the premises used by the service provider were safe to use for their intended purpose and used in a safe way. This was a continued breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection, the provider had failed to ensure safeguarding systems and processes were established and operated effectively. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Systems and processes were not in place to safeguard people from the risk of abuse and harm. Management of safeguarding concerns had deteriorated further since our last inspection and not all staff had completed safeguarding training in accordance with the provider's safeguarding policy.
● The registered manager told us they did not have any knowledge of how to address safeguarding concerns until the consultant had offered support in this area. The registered manager said, "Safeguarding was increasing because I just didn't have the knowledge to be honest, I don't know why there have been so many."
● Some people told us they did not feel safe living at the home due to the conduct of some staff and the registered manager. Two people expressed a wish to leave and said they did not feel safe living at the home.
● We identified an incident involving a person who had left the premises and was found by an off-duty member of staff approximately half a mile away from the home. As part of a recent investigation, the local authority safeguarding team had followed this up with the registered manager, who had denied that it had happened.
● Due to feedback received from people we followed up concerns we had about 'closed cultures' within the home with the consultant. The consultant said, "I do not trust (the registered manager) to run the home. It is clear to me (some of the management team) are wholly untrustworthy" and "I think (registered manager) is coercing people to feel they are in a position where they cannot go anywhere for help. If people and staff are made to feel they can't get help what's the point of the whistleblowing procedures. I can believe that safeguarding information is withheld from me."

Systems had not been established to safeguard people from the risk of abuse. The provider had failed to ensure people were protected from improper treatment and to investigate immediately on becoming aware of allegations or evidence of abuse. This meant people had been exposed to a risk of abuse and harm. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely. The home's internal medicines audits indicated that five people's medicine administration records [MAR's] should be checked each month. However, only one persons had been checked on the three most recent audits. An external pharmacist's monthly MAR check identified repeated record keeping concerns with the supplementary records for 'when required' or 'variable dose' medicines, or for topical preparations (creams).
● MAR's were not always clearly and fully completed. The reason for medicines non-administration was not

always appropriately recorded. We saw examples where amendments to the MAR were not clearly made. Records showing the application of topical preparations and for nutritional supplements did not evidence their use as prescribed.
● Changes to people's medicines were not well managed. We saw three examples where short courses of treatment were not administered as prescribed. Dose changes to another medicine had not been dated making it unclear what dose had been administered.
● We saw examples where doses of medicine were missed because people were sleeping. One person's MAR showed staff had returned later in the morning to apply a patch, but there was no evidence of their other morning medicines being offered again.
● Staff had completed medicines training and competency assessments were completed, but the manager could not evidence how this met the needs of the service.
● Medicines were safely and securely stored. However, there were some gaps in recording the medicines room temperature .

People's medicines were not managed safely. This placed people at risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing levels were not sufficient to meet people's needs and training was not always completed. Dependency levels of people using the service, which are used ensure staffing levels are sufficient, had not been assessed by the registered manager. When asked about this the registered manager said, "Dependency levels have slipped a little bit. I have two on the computer and when I tried to press send data it wouldn't work so I did leave it I'm not going to lie."
● We found significant gaps in the provider's training matrix. We asked the registered manager whether compliance with mandatory training courses had improved. They said, "Yes there are definitely gaps in the training matrix and because there are lots of safeguarding's this has gone on the back burner, obviously it's not up to scratch where it should be and it's in the list to do."
● Recent recruitment records showed references had not been validated and checks were not always carried out when there were gaps in applicants employment history. This meant people unsuitable to work with vulnerable people could be employed by the service to provide care. We discussed recruitment processes with the consultant working with the service. They said, "Our trainer recently explained that she was asked by the registered manager to induct a new worker in December (2021) despite me explaining the suitability checks were not complete."

The provider had failed to ensure staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. This was a continued breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure robust infection control practices were in place and manage the risk of infectious diseases appropriately. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

● Infection control practice was not always robust. We found areas of the home which were unhygienic. Staff's use of personal protective equipment [PPE] had improved since our last inspection; however, occasional errors in staffs use of PPE were still observed.

Care homes (Vaccinations as Condition of Deployment)

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service [had/did not have] effective measures in place to make sure this requirement was being met.

● We reviewed visiting arrangements as part of our assessment of infection control practice at the home and found the provider's policy had not been updated to reflect current government guidance around visiting.
● We observed a visiting professional arrive at the service and enter the home without any checks on whether they were vaccinated or had a negative lateral flow test result. We asked the professional whether this was a regular occurrence they said, "They don't always ask for my test result ."

The provider had failed to ensure robust infection control practices were in place and manage the risk of infectious diseases appropriately. This meant people could be exposed to the risk of infections. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

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 our last inspection we rated this key question Inadequate. At this inspection the rating has remained 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.

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

At our last inspection the provider had failed to ensure auditing and quality assurance systems were robust. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider had failed to implement any auditing systems of the internal management at the home. A consultant had been employed to work with the management team and report back to the provider. However, although the consultant had implemented new systems, the management team had failed to work effectively with them and had put few of these systems into operation. Where they had been implemented, the systems had not been sustained.
- The consultant said, "I've completed risk assessments for staff, some staff have then refused to sign them on the basis of one spelling error, which I find difficult to understand when the same staff have signed paperwork completed by (the registered manager) and the spelling and grammar is poor. The registered manager did not tell me the member of staff had refused to sign meaning they were working without a risk assessment which was needed."
- Internal auditing systems were still not robust and the registered manager acknowledged there were processes they did not understand in relation to meeting regulations. They said, "To be honest we have been concentrating on risk management and audits have fallen behind ."
- The management team had failed to ensure improvement to the general running of the home since our last inspection had been made. When we asked staff and the consultant whether improvement had been made, they raised concerns about the management team's motivation. One staff member said, "(The registered manager) is not interested in the place, so all the staff are saying they don't want to do it (improve the service), why would we want to."

Auditing systems were not robust, and audits were not completed regularly. This was a continued breach of regulation 17(good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● An empowering person centred approach to care was not followed. We found evidence in people's records of restrictive language and people were not empowered by participating in meaningful activities and interactions.

● One person who staff and management were not trained to support, had not been encouraged or supported to participate in meaningful activities or accessing the community in the two years they had lived at the home. At our last inspection we identified this and told the registered manager.

● Staff told us low staffing levels impacted their ability to spend quality time with people. One staff member said, "There's two staff on a lot of the time and it's hard because you can't leave the floor (communal areas), if two people need support. You can't do that and observe the other people at the same time."

● The consultant raised concerns regarding the management team not using agency staff to cover staff shortages. They felt managers did not want agency staff within the home because of the potential for them to whistle blow on the poor practice of managers and some staff.

The provider had failed to ensure care and treatment was carried out to achieve people's preferences and ensure their needs were met. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At our last inspection the provider had failed to notify the commission without delay of notifiable incidents. This was a breach of regulation 18 (Notification of incidents) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 (Notification of incidents) of the Care Quality Commission (Registration) Regulations 2009.

● The provider had improved notification systems since our last inspection and was no longer in breach.

At our last inspection the provider had to ensure their most recent rating was displayed at the premises and on their website. This was a breach of regulation 20a (Requirement as to display of performance assets) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 20a.

● We checked the provider's website on the day of our inspection and found a link to the report from April 2020. In addition to this being the fifth inspection since then, the rating displayed from the April 2020 report was 'Requires Improvement' and not 'Inadequate' which the service had been rated for three inspections prior to this.

The provider had failed to ensure their most recent rating was displayed at the premises and on their website. This was a continued breach of regulation 20a (Requirement as to display of performance assets) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

characteristics
● The provider had failed to engage people using the service and staff. People were often left for long periods without support and staff reported feeling unsupported by the management team and provider.
● We observed on several occasions throughout the inspection some staff did not engage people, ask for the opinions or preferences and did not explain support they were providing. This meant people were not involved in the day to day decision making relating to their care and support.
● Staff reported feeling deflated by comments the registered manager had made about hoping the home would get closed. One staff said, "When they say things like I can't wait till this place closes, it doesn't give staff good vibes when your hearing that off the management. There's similar things on Facebook, they're not professional."
● Staff said they wanted to be engaged and work with the provider for the benefit of the people living at the service. However, they felt when they tried to follow systems implemented to improve engagement and oversight, the registered manager did not check or value the work they had carried out. One staff said, "(New paperwork and systems) are done for a while but then it's not carried on because it's not getting checked, it's just left lying around. We put all the information in and what people have done, what time someone's been changed, what they've drunk, what they've eaten. It's all just left shoved on the side, left on the dining table, the filing cabinet not in order. It's not in order (or organised)."

Continuous learning and improving care
● Learning was not used to inform improvements. Systems to analyse incidents and risk had been reviewed by the consultant. However, these had not been used by the management team to develop their approach or use the information these provided to improve the support people received.
● Important training specific to individuals needs had still not been undertaken. We identified this at our last inspection and shared this with the management team, explaining the impact this could have on people's lives.

The provider had failed to assess monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009.

● Incident reports and care records did not always show what action had been taken to prevent an incident occurring again or to improve people's support. For example, people had new diet and fluid charts in place. However, they were often recorded as drinking significantly less fluid than the recommended level of fluid an adult should have each day, no action was taken to address this and the issues had not been picked up through audits.

The provider had failed to ensure the hydration needs of people were met. This was a breach of regulation 14 (meeting nutritional and hydration need) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The provider had failed to work in partnership with relevant bodies and professionals. The consultant recruited to support the management team had improved contact with professionals. However, the provider and registered manager had not. There was no plan in place for how working in partnership would continue after the consultants support ended.
● The management team were not always open with professionals about incidents which occurred within the home. One staff said, "I think everyone feels the same about the management, that it's hopeless, most staff feel like it's the end."

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 provider had failed to ensure care and treatment was carried out to achieve people's preferences and ensure their needs were met.

The enforcement action we took:

We have issued a notice of decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure they had done all that was reasonably practicable to mitigate risks associated with the provision of people's care. The provider had also failed to ensure the premises used by the service provider were safe to use for their intended purpose and used in a safe way. People's medicines were not managed safely. The provider had failed to ensure robust infection control practices were in place and manage the risk of infectious diseases appropriately.

The enforcement action we took:

We have issued a notice of decision to cancel the providers 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 The provider had failed to ensure people were protected from improper treatment and to investigate immediately on becoming aware of allegations or evidence of abuse.

The enforcement action we took:

We have issued a notice of decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the hydration needs of people were met.

The enforcement action we took:

We have issued a notice of decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure consistent and accurate records were in place or used to identify learning and inform improvement. The provider had failed to ensure auditing systems were robust, and audits were not completed regularly. The provider had failed to assess monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities.

The enforcement action we took:

We have issued a notice of decision to cancel the providers 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 The provider had failed to display their most recent rating and ensure it was accessible.

The enforcement action we took:

We have issued a notice of decision to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform.

The enforcement action we took:

We have issued a notice of decision to cancel the providers registration.