Maria Mallaband 17 Limited

Corinthian House

Inspection report

Green Hill Lane
Upper Wortley
Leeds
West Yorkshire
LS12 4EZ

Tel: 01132234602

Date of inspection visit:
02 November 2022
09 November 2022

Date of publication:
12 December 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Corinthian House is a care home that can accommodate up to 70 people who require support with nursing or personal care needs, some of whom are living with dementia. At the time of our first visit, 48 people were living at the service. On our second visit, there were 47 people living at the home.

People's experience of using this service and what we found
People shared mostly positive feedback about living at the service. Relatives told us they had concerns in relation to several areas of care provided. During this inspection, we were not assured the service provided was always safe and we found widespread shortfalls in the way the service was managed.

The provider failed to implement effective processes to monitor the quality of the service, drive the necessary improvements and to identify the issues found during our inspection. We continued to identify some issues found at previous inspections, and we found new concerns in relation to safety of people and lack of person-centred care. Records were not always complete or contemporaneous.

Medicines were not always managed safely. Most risks to people's care were assessed, however we found concerns in relation to how some risks were managed. We identified concerns about people who were at risk of choking not being safely positioned while having their meals. Several people living at the home had lost weight and evidence reviewed did not evidence action had always been taken in a timely way. Risks to people's skin integrity was not always well managed in line with people's care needs and plans. Recruitment was managed safely and infection and prevention measures were followed by staff.

People, relatives and staff raised concerns about staffing levels. The provider was using a tool to assess the level of staff required on shift. After reviewing all the information, we made a recommendation for the provider to review their staffing levels and staff deployment.

People were not always supported in a person-centred way during mealtimes. We observed instances when staff did not display the skills to appropriately support people living with dementia. Although staff's training was up to date, this covered only basic aspects of care and did not cover other clinical needs of people living at the home. Staff told us they did not feel supported in their roles. The home manager told us about their ongoing plans to provide staff with additional training.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We received mixed feedback about staff's approach; some people and relatives told us staff were kind and caring, others told us staff were not always responsive.

We found concerns in relation to people not being offered and provided with frequent baths or showers. There was no evidence of regular and meaningful activities being offered to people. Care plans had information about people's needs, but we found examples where this was not consistent or complete.

There was a manager in post; they had not yet submitted an application to register. We received mixed feedback from people, relatives and staff in relation to the management of the home. During this inspection, we found a substantial deterioration in the level of care people were receiving.

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 requires improvement (published on 19 November 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, we found the provider remained in breach of regulations.

Why we inspected
We undertook this inspection to follow up on specific concerns which we had received about the service, namely concerns received about staffing levels, medicines management and safeguarding. A decision was made for us to inspect and examine those risks.

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

Enforcement and Recommendations
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.

We have identified breaches in relation to person centred care received by people, safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Corinthian House

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 was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was conducted by 3 inspectors on the first day, and 2 inspectors on the second day. An Expert by Experience supported the inspection remotely. 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
Corinthian House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Corinthian House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection, there was not a registered manager in post. There was a home manager but they had not submitted an application to register.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 2 November 2022 and ended on 16 November 2022. We visited the location on 2 and 9 November 2022.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including information about important events which the service is required to tell us about by law. We requested feedback from other stakeholders. These included the local authority safeguarding team, commissioning teams, infection and prevention control team and Healthwatch Leeds. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 4 people using the service and 11 relatives about their experience of the care provided. We observed care in the communal areas to help us understand the experience of people. We spent time observing care in the communal lounges. 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 gathered information from 11 members of staff including the home manager, regional director, head of quality, quality excellence partner, nurses, care practitioner and care staff.

We reviewed a range of records. This included 4 people's care plans, risk assessments and associated information, and other records of care of other people to follow up on specific issues. We also reviewed multiple medication records. We looked at 3 staff files in relation to recruitment, training, supervision and appraisals. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained required improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

- Most risks to people's care were assessed, however we found concerns in relation to how some risks were managed.
- We identified concerns about people who were at risk of choking having their meals in their bedroom, on their own, while laying down in bed. We asked the manager to take immediate action. On our second visit, we requested an update on the actions taken and we were not assured action was being taken in a timely way. We asked the manager to prioritise this work. After our second visit, the manager told us people who were at risk of chocking had had their care plans reviewed and the manager had increased their checks during mealtime. There had not been any choking incidents at the home.
- Risks to people's skin integrity was not always managed in line with their care needs and plans in place. There were gaps in repositioning charts for people with pressure ulcers, lack of evidence of prescribed creams applied and inconsistencies in care plans. The manager told us they would review this area in people's care and confirmed people with pressure ulcers were healing well and being supported by relevant healthcare professionals.
- People living at the home could, at times, express distress or agitation, such as verbal and physical aggression. Although care plans provided guidance to staff on how to support people if they were emotionally distressed, this was not always followed.
- The emergency evacuation folder where people's personal emergency evacuation plans (PEEPs) were located was not up to date. We discussed this with the manager and they updated this folder immediately.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us the actions they had taken and were planning to take to address the issues found during the inspection.

Using medicines safely

- Systems for supporting people with their medicines were not safe.
- Some people living at the service required specialised equipment to allow their nutrition, fluids and medication to be administered directly into their stomach (PEG), due to risk of choking. We found there was a lack of evidence of adequate management of people's PEG. After our inspection, the manager showed us the changes they had put in place to ensure this was well recorded.
- Records did not assure us topical medicines were being applied as prescribed.

● Prescribed supplements used to thicken the drinks for people at risk of choking were not always recorded when given to people.
● Improvements were required to ensure information about people's 'as and when' required medicines were detailed to guide staff administering this medication.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider was using a dependency tool to ascertain the numbers of staff required to meet people's needs and the rota was in line with what the dependency tool indicated. However, evidence gathered during this inspection, indicated concerns with staffing levels.
● There had been one day when the required staffing levels had not been in place, but the manager assured us with the actions taken to manage this one off incident.
● The provider regularly used agency staff. Procedures were in place to ensure agency staff were aware of people's needs and properly inducted into the service; but evidence made available during inspection visit did not confirm this was always being followed.
● People and relatives shared concerns about staffing levels and staff continuity. People told us, "[Living at Corinthian House] it is more or less all right, but they are short staffed" and "They keep changing staff every 3 minutes. They [staff] come as quickly as they can," Comments from relatives included, "There doesn't seem to be any staff around;" "I visit during the evenings and often there are no staff around on the 3rd floor;" "Never the same staff and a heavy use of agency staff who have no idea who the residents are or their needs" and "Extremely poor staffing."
● Staff also raised concerns about staffing levels and told us they did not always have enough time to complete certain aspects of people's care. A staff member told us, "No one here [Sycamore unit] has time for a bath or a shower."

We recommend the provider reviews their staffing levels and takes action to ensure adequate deployment of staff.

● Staff were recruited safely, and the home manager told us about their ongoing recruitment activity.

Systems and processes to safeguard people from the risk of abuse
● The manager was aware of their safeguarding responsibilities. Feedback received from stakeholders indicated information about ongoing safeguarding concerns had not always been provided promptly or with the level of detail requested.
● People told us they felt safe living at the service.
● Staff had received appropriate training in this area, knew how to identify signs of abuse.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the

premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Relatives and friends were able to visit people living at the home, in line with visiting guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People were not always supported with their nutritional needs in a person centred way.
- Relatives raised concerns regarding their loved ones losing weight. Their comments included, "[Relative] has been weighed and we have found [their] weight fluctuates so much each month. It seems staff don't really know or understand what they are doing which is concerning;" "[Relative] has lost weight" and "I have been raising many complaints about [relative's] weight."
- Since being in post, the manager had identified several people who had unintentional weight loss. Although we were assured appropriate referrals had been completed in September 2022, when we reviewed records from previous months, we could not always confirm if action had been taken in a timely way. In our review of records, we also identified a high fluctuation in people's weights records; the home manager told us they were in the process of providing additional training to staff in this area.
- We found examples of meals not always being offered by staff in a person-centred way. We observed staff leaving breakfast in front of people while they were asleep, with no attempt made to wake them up gently and encourage them with the meal. We observed people living with dementia eating their meals in their bedrooms, on their own, staff were not present to encourage food intake and records did not evidence eating in their bedrooms was people's choice.
- Relatives raised concerns in relation to the provision of people's foot care. Comments included, "We have noticed [relative's] toe nails are very long and thick" and "I have had to ask for a chiropodist to visit [relative] as [their] toe nails are extremely long." We shared concerns with the manager; they explained there had been a gap in provision of care while a new chiropodist was being recruited. Most people had been supported with this service between July and October 2022, but we also found examples of people not seeing a chiropodist for over 19 weeks.
- We found a lack of evidence of people being provided with oral care. This area of people's care was not evidenced in care notes and in our conversations with staff we were not assured this was provided regularly.

This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured care was appropriate and met people's needs. This placed people at risk of harm.

● Most people shared positive feedback about the quality of the food. One person told us, "Food? it is excellent. [Name of chef] can cook any tea or breakfast, beautiful."
● During this inspection, we also found examples of the provider working with other professionals to meet people's needs such as tissue viability nurses and the mental health team.

Staff support: induction, training, skills and experience
● Staff told us they did not always felt very supported.
● Evidence reviewed showed staff's training was up to date however, considering the clinical needs of people, we found training covered only basic aspects of care. For example, several people were at high risk of developing issues with their skin integrity; we reviewed the provider's training matrix and staff had not received specific training in this area. Some people lived with dementia and could, at times, express distress or agitation; yet the provider's training matrix only indicated staff had received dementia awareness training. The manager had identified the team's training needs and action was being taken. For example, during our first visit nurses were being provided with additional training.
● We reviewed evidence confirming supervisions and observations of practice were taking place.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● MCA and best interest decisions were being completed for relevant decisions about people care.
● DoLS applications had been applied for when required.
● Staff's training was up to date in this area.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

Respecting and promoting people's privacy, dignity and independence

● People were not always offered or supported to have a bath or a shower. Relatives raised concerns about their loved ones' appearance and hygiene. We reviewed people's records, and these showed people were being supported with regular personal care but there was no evidence of showers or baths being offered or provided. We discussed our concerns with the manager. After our inspection, the manager told us they had implemented additional checks and monitoring around this area of people's care.

We found care was not always delivered in a way that met people's needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed staff discussing people's private matters in communal areas. We saw personal and confidential information about people being accessible to others who might not have the right or permission to access it. We shared these concerns with the manager and asked them to take action. We did not find the same concerns during our second visit.

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

● People and relatives shared mixed feedback about staff being caring and kind. Comments included, "Staff appear to be [kind], often they come into my [relative's] room and engage with us plus some can be welcoming;" "I would say some are" and "Some are."

● During this inspection, we saw examples of staff not always responding to people living with dementia in a way that was centred around their needs. For example, when one person said they wanted to go home, a staff member replied, "Ooh so do I;" "Well you can come home with me when I go" and "Your son will come at the weekend and he'll take you home". These replies did not show staff understood people's emotional needs or responded appropriately and respectfully.

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

● People were not always involved in making decisions about their care.

● We reviewed people's care plans and reviews of care and there was no evidence of people and relatives being involved.

● Relatives shared mixed feedback about being involved in reviewing their loved one's care. Most relatives told us they had not been involved, but others told us, "Yes I have [been involved in reviewing care], at initial admittance" and "Yes, I filled in the 'This is me' file."

● The manager told us about their ongoing plans and actions to involve relatives and invite them to meetings at the home.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not offered regular opportunities to interact or be involved in activities. Most relatives told us their loved ones were not engaged in meaningful activities. Their comments included, "[Relatives] is not stimulated at all. There is no attempt to even speak to [them]" and "Personally I think not [engaged in activities] but I am not there all day."
- During our visits, we did not see structured activities taking place to engage people. We observed people in communal areas watching passively and asleep; staff present were focused on care tasks and did not offer meaningful interaction to people. We observed 1 person who was emotionally distressed, and staff members present did not attempt to offer reassurance or divert the person's attention to an activity of their interest.
- We asked to see records of activities on our second visit, but this was not available. After our inspection, the manager told us although activities were happening these were not being recorded.

We found care was not always designed or delivered in a way that met people's needs and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Some aspects of people's care plans were detailed and person centred. However, other areas needed further information or to be updated. For example, 1 person had been losing weight, the GP had visited, prescribed supplements and advised weekly weights to be completed. This information had not been updated in this person's nutritional care plan. Another person's moving and handling equipment and their mobility needs were not consistent in different areas of their care plan. We discussed this with the manager and they told us about their ongoing work to review people's care plans.
- People's care plans included reference to their end of life wishes and preferences. The manager told us anticipatory medication had been prescribed for people who required it and how they worked with relevant professionals to meet the needs of people who required palliative care.

Improving care quality in response to complaints or concerns

- The provider had policies and procedures in place to manage complaints. We reviewed how this was being managed and found it to be appropriate
- People and relatives told us they knew how to raise a concern or a complaint. We received mixed feedback in relation to how confident people and relatives were that the manager would investigate and address if

they raised any concerns.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were assessed, and plans put in place to support people with this area of their care.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- We found people did not always receive safe and person-centred care due to widespread failings in the management and oversight of the service.
- There was a significant lack of effective oversight and monitoring of the service. As a result, risks to people care were not being appropriately managed or monitored, such as risk of choking or risks with skin integrity, medicines were not always well managed, people's nutritional needs and care was not always delivered in a person centred way, particularly for those people living with dementia.
- We found the quality assurance processes in place had not been effective in either identifying the issues found at this inspection or in driving the necessary improvements. For example, monthly mealtime experience audits and medication audits were being completed, but these had not identified the issues we found during this inspection in relation to lack of person centred care delivered during meals. Care plan audits had been completed and we reviewed one which highlighted improvements was required with recording of activities, but this information was not used to ensure activity provision was improved and appropriately recorded. Audits were being completed on behalf of the provider, but the issues identified during this inspection had not been noted.
- Records and decisions about people's care were not always kept secure and there were not accurate, complete and contemporaneous records of the care people required and received.
- During this inspection, information requested was not always made available in a timely way or provided.
- In our previous inspection, the service was rated Requires Improvement and found it to be in breach of regulations. At this inspection, the provider continued in breach of regulations and we found new breaches.

Systems were either not in place or robust enough to demonstrate effective oversight and management of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- In our review of quality assurance and monitoring of the home, we found some examples of issues identified by the manager being addressed, such as moving and handling training not being up to date or call bells not being in reach for people to use. We did not find issues in these areas during this inspection.

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

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

● People's care needs were not always being met as detailed in this report and this had an impact on their safety and quality of life.

● People, relatives and staff shared mixed feedback about the management of the service. Staff said they felt unvalued. The manager told us about their ongoing work with staff to improve the culture at the home.

● The manager told us residents' meetings had been suspended since the COVID-19 pandemic had started and these had not resumed yet. The manager told us they frequently sought feedback from people in their daily walkarounds.

● We reviewed the responses of the relatives to the survey completed in 2021/22 and issues raised included lack of communication, staffing, activities and people's hygiene. These were issues that we identified during this inspection.

Working in partnership with others

● The service worked in collaboration with a number of organisations to support care provision. This included working with health care professionals from multidisciplinary teams to make sure people had their health and social care needs met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service does not always ensure people's needs and preferences were met in line with their requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's care and medication were not always managed safely.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The quality assurance processes in place had not always been effective. Records of care were not always accurate and complete.

The enforcement action we took:

We issued a Warning Notice.