Optima HCI Limited

Baylham Care Centre

Inspection report

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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
Baylham Care Centre is a care home with nursing. At the time of our inspection 47 people were being provided with care and support which included younger adults and older people, some of whom have complex mental health and physical needs. The service can support up to 55 people.

People's experience of using this service and what we found
We found significant concerns around how the service was managed particularly with regards to health and safety and risk management.

Risks to people's health, safety and welfare were not managed effectively, placing them at significant risk. People's care records were not always person centred and accurate. They lacked information to guide staff in how to meet their needs safely and effectively

People were not consistently supported to have maximum choice and control of their lives and staff did not support them in the least restrictive ways possible and in their best interests; the policies and systems in the service did not support this practice.

We received mixed feedback about staffing. People who were in receipt of 1:1 care were consistently supported by agency staff who were, at times unfamiliar to them. Staff training was not up to date. There were gaps in the skills and knowledge of staff across multiple areas of the service. Training in supporting people with complex needs and behaviours that may challenge was insufficient.

The home was not well managed, and the provider lacked oversight of quality standards and the care that was being delivered. Audits were not effective and had not identified the issues found during the inspection. A member of staff told us, "In the past everyone had worked very hard for the home to achieve an outstanding rating and it only took a short period of time to ruin that hard work."

We observed many people to be happy living at Baylham Care Centre, supported by caring staff. People and their relatives did not express any significant concerns regarding the service. Many relatives also acknowledged, however, they had also had minimal time within the service in the past year due to the COVID-19 pandemic.

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

This service was registered with us on 9 September 2019 and this is the first 'ratings' inspection.

The last rating for the service under the previous provider was Outstanding published on 26 October 2017.

Why we inspected

The inspection was prompted in part due to concerns received about the management of risk and people's safety. A decision was made for us to inspect and examine those risks.

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

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding, need for consent, staffing, good governance and notifications.

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 work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore 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? 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**

Baylham Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
This inspection was carried out by two inspectors 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
Baylham Care Centre 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.

There was no manager registered with CQC at the time of our inspection visit. The previous registered manager had left the service in December 2020. In the absence of a registered manager, the provider is legally responsible for how the service is run and for the quality and safety of the care provided. Just prior to our inspection visit we were told the new manager was also leaving and had handed in their resignation however a week later they changed their mind and decided to stay. We are awaiting this managers application to register.

During our inspection visit the provider was represented by an operations manager who was also the providers nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
We gave a very short notice period of 15 minutes to the service prior to the first day of the inspection. This was to ensure the safety of all involved and to assess any risks in respect of COVID-19. The second day was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service and 15 relatives about their experience of the care provided. We also had email contact with a further seven relatives. We spoke with eight members of staff including; care staff, a housekeeper, nurses, the manager, the deputy manager and operations manager. We also had email contact with a further six staff in order that they could provide their feedback.

We spoke with two visiting healthcare professionals. We reviewed multiple people's care files, daily records of care and medication records. We also reviewed two staff personnel files and viewed agency staff profiles. We also looked at a sample of the service's quality assurance systems, the provider's arrangements for managing medication, staff training and supervision records, complaint and compliment records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received additional information and feedback from professionals who work in the local authority safeguarding team who were familiar with 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.

This is the first inspection for this newly registered service. This key question has been rated 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

- Management of risk was inadequate. Risks to people's safety and welfare were not being assessed, mitigated or managed effectively in order to keep people safe.
- Where risks were identified, action was not always taken to reduce the risk of harm to people. For example, in October 2020, and following an incident that occurred at the home, an issue with the consistent and secure closing of some internal doors had been identified. Following this we had been informed by the provider that they had taken action to ensure the doors were secure. Despite these assurances from the provider during our visit, we found, yet again, one door that should have closed securely, remained open This meant that people may have been able to leave by this door when it was not safe for them to do so or there was an increased risk of them falling.
- Some staff told us that there had historically been issues with the safety of the doors that had not been addressed. One member of staff said, "There are still some doors that don't close properly. It's now the door for the deliveries, [people] could exit the building that way." We followed this concern up during the second day of our visit and found this door to be secure at that time.
- Other environmental risks were present and action to mitigate had not been taken. We found free standing wardrobes in people's rooms which were not fixed to the wall and therefore presented a risk as they could be pulled over.
- People living on the top floor at the service (referred to as 'the attic') had balconies accessible from their bedrooms. Each balcony contained an external table and chair set. The height of these and the risk of a fall from considerable height, should a person have climbed on to the furniture, had not been identified or considered.
- The provider had consistently failed to adequately assess and mitigate against the risks of serious harm to people who had expressed a wish harm themselves or commit suicide. This placed people at significant risk of harm.
- Where care plans had been created, and risks to people's health, welfare and safety had been identified, there was a lack of guidance for staff to follow, to protect people from harm, particularly where they had expressed feelings of self-harm or suicide.
- Several people had been involved in a number of behavioural incidents that presented a risk of harm to themselves or others. There were no clear strategies in their care records about how to minimise the risk of these incidents. Many staff told us the training they had received did not equip them with the skills required to manage risks associated with supporting people who had behaviours that may challenge.

The shortfalls we found in safety demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

● People were not always being safeguarded from the risk of abuse. During February 2021, following significant safeguarding referrals and concerns raised about safety and quality of care, the local authority placed a suspension on new placements at the service.

●The provider had policies in place to help protect people from the risk of abuse, however, we found these were not effective. The concerns we found had not been identified and action had not been taken to protect people from any further potential harm.

● The provider had not recognised potential safeguarding concerns or reported concerns such as unexplained injuries, to the local authority in line with local safeguarding protocols.

● There was a lack of effective systems in place to ensure that concerns were reported and fully investigated in a timely manner. For example, we found that staff had completed incident reports when they found unexplained marks or bruises on a person's body, but records did not demonstrate what follow up actions were taken. Records showed some staff undertook their own investigation, this meant there was a risk that concerns could go unreported, and was not in line with safeguarding procedures.

The shortfalls we found in relation to safeguarding demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment

● Staff told us of intermittent challenges over the past year with staffing levels due, in part, to the COVID-19 pandemic. Agency staff were used to fill any staffing gaps and frequently to provide specific 1:1 care that some people required to ensure that their needs and safety could be met.

● There were a number of agency staff who did not speak English as a first language and did not always have sufficient grasp of the English language to enable them to perform the job role effectively. People and their relatives told us this impacted communication. Staff spoke of challenges sharing information and safe working due to language barriers.

● During our inspection visits we observed there were sufficient staff to meet people's care and support needs. Call bells were operated via a 'silent call bell' which made it hard to hear how quickly they were responded to. Some people and relatives spoke of their frustration with the system that meant they couldn't hear an audible sound when they pressed their alarm and therefore some anxiety was created that help may not be on the way. The manager told us they were in the process of auditing call bell response times.

● People were supported by staff who had been recruited safely. Pre-employment checks included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

Using medicines safely

● Peoples' medicines were managed safely. Medicines administration records indicated people received their medicines as prescribed.

● Staff were patient when they supported people to take their medicines.

● Medicines were stored, managed and administered safely in line with best guidance. There were regular medicines audits to ensure any errors were quickly identified. Medicines were safely administered, stored and recorded by staff who had the required knowledge and skills.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely. Some relatives told us that they

had not always witnessed staff wearing face covering masks correctly, we raised this with the manager who said they would re-address this with staff

- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Some staff told us that supervision had not been routinely carried out to ensure they were supported and that their competence and skills were up to date and maintained. We asked the provider for evidence that staff supervisions were taking place however we did not receive this prior to writing this report. Some staff told us they had not received a supervision meeting in over a year. This meant opportunities to manage staff performance may have been missed.
- Staff training was not up to date in all cases. There were gaps in the skills and knowledge of staff across multiple areas of the service such as, safeguarding people from the risk of abuse, fire safety, moving and assistance and positive behaviour support. We have not received a clear response from the provider about when this training will be brought up to date.
- The staff who cared for people who displayed behaviours that challenged themselves and others did not always have the experience or training they needed to manage and reduce these behaviours effectively. People could not be assured that all the staff would have the skills to meet their needs and keep them safe.
- Some people, relatives and staff told us there were a number of agency staff working at the service who had insufficient English language skills to interact and communicate with people. Prior to them commencing work with people they had not been provided with any training in the English language in order to enable them to understand people. This also impacted on their ability to read and record in care plans, risk assessments and communicate with the emergency services should the need have arisen.
- The provider employed an 'in house' physiotherapy team to provide services to people, who requested this, on a privately purchased basis. Records we viewed showed the physiotherapy was not always delivered by a qualified therapist. There was also no evidence of the therapists receiving clinical supervision. Enquiries are ongoing as to whether this is a service that people could have alternatively accessed through NHS community services if there is an identified need.

The above evidence shows a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following this inspection, the provider sent us lists of dates they said staff supervisions had taken place.
- We received positive feedback from relatives about the healthcare their family member received at the service. One relative told us, "[Family member] says the level of healthcare they get is brilliant. They also liaise with [family member's] local doctor on their behalf regarding their changing health." Another relative

informed us, "Yes, [family member] gets everything through the doctor if they have any problems, they get the doctor as soon as possible if needs be."
● Some staff told us they had not felt supported at work for a while however this had changed since the arrival of the new manager who they found approachable and supportive.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● MCA and DoLS processes were not always followed correctly to ensure that people's rights were upheld, and decisions were made in the best interests of people who lacked the mental capacity to make specific decisions
● MCA capacity assessments were not always accurately considered and completed. A safeguarding referral was made by a healthcare professional due to inappropriate application of the MCA and DoLS legislation.
● An effective system was not in place to ensure best practice guidance was followed when assessing and providing care. For example, we identified shortfalls relating to the management of risk, protection from harm and MCA.

The above evidence shows a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People and relatives spoke of improvements to the meals in recent weeks. One person said, "The food has improved. The custard used to be hard and pastry was like cardboard." The manager told us they had addressed the quality of food being prepared following negative feedback received.
● We observed staff supported people in a calm unhurried manner with their meal. One person changed their mind when they saw the meals arrive and there was sufficient available to accommodate change.
● People that were nutritionally at risk were monitored through frequent recording of their weights. In addition, food and fluid charts were kept when necessary to monitor and track people's intake. One person's relative told us, "[Family member] has put on weight here, they like the food."

Adapting service, design, decoration to meet people's needs
● We looked at how people's needs were reflected in the adaptation, design and decoration of the premises. The building was set over three floors and was accessible via a passenger lift.
● There was an issue with the consistent safe closure of the internal doors in the home as covered in the key

question of safe within this report. Following previous unsatisfactory audits being completed, the provider employed an independent health and safety auditor to review the premises and at the time of our inspection was awaiting the outcome. However, in the interim, risks were not mitigated.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- Due to the concerns identified during this inspection, we could not be assured that people received a high quality, compassionate and caring service. We have taken these concerns into account when rating this key question.
- People were not always well-supported with regards to their specific mental health needs and risks to their health and safety. This was not respectful of their equality and diversity.
- Processes were not always followed correctly to ensure people's rights were upheld and their capacity to make their own decisions considered and supported.
- Most people, and their relatives, that we spoke with told us they were happy and enjoyed living at the service. One person told us, "All staff are caring, [staff member] is particularly good. [Staff member] put my favourite programmes and operas on a memory stick for me in their own time."
- Many relatives acknowledged that they had been unable to spend any significant amount of time in the service over the past year due to the pandemic. Despite this they told us they felt confident that their family member was well cared for. One relative said, "We think [family member] is happy there. [Family member] seems content, we don't get any impression that they are not well cared for." Another relative told us, "As a family we have no doubt that without the care, love and expertise of staff at Baylham [our family member] would not still be with us." A third relative said, "I do think the staff are very caring, very much so. Before this recent lockdown I saw that they know [family member], they have a friendly relationship with them. It is more like a friend than their professional relationship in the best possible way."

Respecting and promoting people's privacy, dignity and independence

- One person's relative shared with us how having to wait for assistance from staff with their personal care had compromised their dignity. They said, "Last week [family member] requested to go to the bathroom at 11am and because of a staff meeting there wasn't two people available to take them until 11.45am."
- People's relatives told us how their family member's independence was promoted and encouraged. One relative said," I think that they do get [family member] to do things for themselves like brushing teeth." Another relative commented, "I believe that they are helping [family member] to retain their independence. My [family member] is very independent."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people's needs were not always met.

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

- People were at risk of receiving inconsistent support.
- An effective care planning system was not fully in place.
- People's needs were not appropriately assessed or planned for and this had the risk of potential impact on their health and wellbeing.
- Not all care plans contained sufficient information to ensure staff knew how to deliver people's care in a safe and person-centred way.
- We identified shortfalls in care records relating to the management of risk, supporting people with distressed behaviours and the MCA. These shortfalls meant people were at risk of receiving unsuitable or inconsistent care because staff did not always have clear guidance about how to support people's specific individual needs. This risk was exacerbated by the use of agency staff who were not familiar with people.
- People's end of life care plans included detail of 'do not resuscitate' orders (DNACPR) but lacked detail of their personal preferences. Improvement was needed to include more detail to ensure people's wishes were recorded and known to the staff supporting them.

Improving care quality in response to complaints or concerns

- A complaints policy was in place. We received mixed feedback about the complaints procedure and how effective it was. A relative said, "There are complaints that are ongoing it is very difficult to know who to complain to. There were no leaflets anywhere informing me what to do if I wasn't happy, I have no idea of who is the higher management is."
- We reviewed the log of complaints received by the service and the actions taken in response. Learning was not consistently taken forward and recorded meaning the service did not always learn from concerns raised and use them as a means identify improvements.
- Other relatives were more positive about the effectiveness of the complaints procedure saying, "I have no complaints. I would be happy to raise a complaint and know who I would contact." Another relative told us, "I haven't had cause to make a complaint, but I would if I had the need. I would go to reception and then the nurse, I haven't ever spoken to the manager."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were considered as part of their care plans.

● We were told information in pictorial format and large print was available to accommodate communication needs if required.

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

● Staff were employed to specifically support people to take part in activities and their hobbies.

● Relatives fed back to us that due to COVID-19, activities had been reduced so that the activities staff could focus on supporting people to visit their relatives safely using the service 'visiting pod'. However, since visits had been ceased more recently, activity staff had returned to their role and visits had been reduced to 15-minute weekly video calls.

● Some relatives of people who had complex support needs felt that there were limited opportunities for people who remained in their bedrooms or had 1:1 support to take part in activities. They were, however, also mindful of the impact of the pandemic.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's quality assurance systems were not robust. There was ineffective governance and poor oversight at manager, regional manager and provider level which had failed to fully identify shortfalls in the service putting people at risk of harm.
- Auditing systems were not effective. We identified shortfalls in many areas of the service including the assessment and management of risk, the safeguarding of people from the risk of abuse, MCA, training, and governance. These issues had not been identified by the providers governance systems before our inspection.
- There had been a number of management changes which had destabilised the service and resulted in inconsistency in approach.
- Timely action had not been taken to address known issues. During February 2021, following significant safeguarding referrals and concerns raised about safety and quality of care, the local authority placed a suspension on new placements at the service. At this inspection we found that these safety concerns were not being addressed in a timely manner and effective leadership remained an issue.
- The provider had a system in place to gather feedback about the service however there was no evidence of how they used that feedback to learn from people's experiences of their care and support.

One relative told us, "The previous owner and manager asked for feedback. There were staff, relatives and residents' meetings on a regular basis, and they were about menus, places to visit, and events. But not with the new management. Another relative said, "I had a feedback questionnaire to comment on, there was no come back from it and I have heard nothing since."

- This meant that the provider had not sought people's feedback to understand their experiences of their care and support and identified any actions needed and any changes needed.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Collaboration and communication with external organisations was not always effective. Important safeguarding information had not always been shared with the local authority safeguarding adults' team for their assessment and investigation as appropriate.
- Despite the support and input of several health and social care professionals on issues that had been identified, progress to make the improvements needed had either not happened or was very slow. Lessons were not learned. This was due to a lack of ownership and accountability both in the service but also at

senior manager and provider level.

The above shortfalls constituted a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were mostly positive about the new manager who had been in place since December 2020 and said they were supportive and that they were hopeful improved communication would continue.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;

● The provider had failed to notify CQC about all safeguarding allegations or incidents. This is a requirement of the provider's registration so that where needed, CQC can take follow-up action.

The failure to notify CQC appropriately is a breach of the Care Quality Commission (Regulations) 2009 Regulation 18