Island Court Care Home Limited

Island Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Island Court Care Home is a care home which provides personal care with nursing for up to 55 people, including people with dementia. At the time of our inspection there were 54 people using the service.

People's experience of using this service and what we found
People were not always protected from the risk of harm; we found systems were not effective in reducing risks to people from falls, the spread of infection or choking. Systems in place to safeguard people from abuse were not robust and processes for learning lessons were not effective in driving improvements.

Quality assurance systems were not always effective for people. This meant the action taken by the provider had not always ensured people received consistent, caring and safe support. People did not always experience a positive and empowering culture at Island Court Care Home.

People were not always treated in a compassionate, respectful way. Some people experienced inconsistencies in the caring nature of staff members. People were supported to practice their religion and the service considered people's cultural needs and wishes. People were supported to express their views and be involved in their care, although people didn't always feel this was effective.

People and staff didn't always feel there were enough staff, although the service monitored people's needs to assess the number of staff needed. People received their medicines safely. 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; however, the policies and systems in the service did not always support this practice. People's capacity was not always assessed and their best interests considered when it would be appropriate to do so.

People were not always supported by staff who had up to date training; this was exacerbated by several new staff members who were in the process of completing their induction. People's needs and choices were assessed and the service ensured people's dietary needs were well met. People were also supported to access healthcare and external support as needed.

People spent long periods of time without engagement. However, there was an activities coordinator and plans in place to increase support with activities. People were supported to be part of the local community. People's communication needs were considered and catered for. Systems were in place to seek feedback and resolve people's complaints.

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

Rating at last inspection
The last rating for this service was requires improvement (published 19 November 2021).

Why we inspected
The inspection was prompted in part due to concerns received about the management of safeguarding incidents and the quality of internal investigations in accidents or incidents. A decision was made for use 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 COVID-19 and other infection outbreaks effectively.

We 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.

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

Enforcement
We have identified breaches in relation to how people's safety was managed, how people were safeguarded from abuse, their rights promoted, people being treated with dignity and respect and how the service was run 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 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 always well-led.

Details are in our well-led findings below.

Requires Improvement

Island Court Care 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.

Inspection team
Two inspectors carried out this inspection.

Service and service type
Island Court Care Home 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. Island Court Care Home 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection 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. 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 used all this information to plan our inspection.

During the inspection
We spoke to seven people and seven relatives about their experience of the care provided. We spoke with six professionals who have contact with the service. We spoke with 10 members of staff including a director for the provider, Registered Manager, Clinical lead, and seven members of staff. We reviewed a range of records. This included five people's care plans, medicine administration records (MAR) and three staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People didn't always feel safe. One person said, "Sometimes I don't feel safe, not when [another person's name] is moving around." Another person told us, "Just lately, I haven't felt so safe because you get some people wandering around at night, opening your door and coming in."
- Allegations of abuse weren't always reported or investigated. For example, we found incidences of people alleging they had been hurt by staff but no further action was taken. We raised these with the provider to consider whether any retrospective action was required.
- Prior to our inspection, we received feedback from professionals who had been involved in a safeguarding matter at the service. They highlighted concerns that the quality of the internal investigation was insufficient and the severity of the incident was downplayed by the provider. Our inspection identified this was a theme; we reviewed several incidents where serious matters weren't reported to external agencies, meaningfully investigated or actions taken to minimise further risks to people.
- Appropriate actions were not taken when people displayed sexualised behaviour. There was a failure to conduct reasonable enquiries with people to identify the relevant circumstances; this included considering people's ability to consent to a sexual relationship. This put people at risk of harm.
- Systems were not effective in identifying learning following incidents at the service. This meant opportunities to prevent further incidents could have been missed. For example, some documents recorded learning as 'all residents needs to be documented in care plans', when this is standard practice.
- Not all staff had completed safeguarding training. Records showed several staff did not have valid training in place for safeguarding adults. The provider informed that there were a number of new staff who were in the process of completing their initial training.

The provider had failed to take action to safeguard people from the risk of abuse. This included a failure to escalate concerns and take steps to minimise any ongoing risk to people. 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.

Preventing and controlling infection; Assessing risk, safety monitoring and management

- We were not assured the provider was using Personal Protective Equipment (PPE) effectively and safely. On arrival at the service, we observed that several staff were not wearing masks. During our inspection we noted a number of occasions where staff weren't wearing a mask or were wearing them incorrectly. This included occasions when staff were supporting people in their rooms.
- We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. When we arrived we observed several issues that could compromise infection control. For example, some cutlery laid on tables ready for breakfast time was soiled. We observed a sling on the floor in

the corridor. A soiled hoist and wheelchair were observed being used to support someone.
● A tea trolley in the dining room was soiled and storing stained mugs for people's drinks. One person told us, "The mugs are not in good condition, one yesterday was badly cracked and chipped." The provider said they would address this.
● Information about falls at the home was not effectively analysed so actions could be taken to minimise further risks to people. Accident and incidents audits showed several falls at the service under similar circumstances. However, there was no detailed analysis to detail whether the timing, location or people involved suggested any trends.
● People were not always given timely support when they requested help. During our inspection, we noted a person who was at risk of choking began to cough whilst having their meal and shouted out for help. Staff members nearby did not immediately go to aid the person, but continued with tasks they were already completing. A senior carer attended the dining room to support the person. Records showed that approximately half of the staff team had received training in supporting people with swallowing difficulties, which may have impacted staff awareness. A lack of staff attention put the person at risk of harm.
● Serious injuries were not always adequately documented and followed up to reduce risks to people. We identified an incident where a person had sustained an injury, but the accounts documented in the incident reports and safeguarding referral were significantly different. The online system did not have any details of the incident, recording of the extent of the injury or actions taken to prevent further occurrences.

There was a failure to protect people through infection control practices and robust monitoring and management of risks. This put 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) Regulation 2014.

● 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 responding effectively to risks and signs of infection.
● 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
The provider was facilitating visits for people living in the home in accordance with current guidance.

Staffing and recruitment
● Staffing levels were maintained at the assessed level to support people safely. The provider had a dependency tool in place to assess staffing needs and staffing numbers were in line with this level. However, we observed that people were sometimes left waiting for support.
● People told us there weren't always enough staff to meet their needs. One person said, "I don't think they have enough staff." Another told us, "If there aren't many staff in, if they are still getting people up you might not get a cup of tea."
● Staff members consistently told us there weren't enough staff, particularly on the nursing unit where people required more support. The registered manager advised there were several new staff in place who were adjusting to their roles and it was hoped with time this would ease the pressures within the team.
● Three staff files showed the staff members had been recruited appropriately. The provider had completed past employment and police checks before the staff members started at the service to make sure they were suitable to work with people.

● The provider had a system in place to ensure nursing staff were suitably registered with the regulatory body.

Using medicines safely

● People at Island Court Care Home were receiving their medications safely. Where people were prescribed 'as required' medications (PRN), there were protocols in place to advise staff about their use.

● Staff had received medication training and felt they had the skills and knowledge to support people with their treatments. Competency assessments were in place to review staff practice when administering medicines.

● Weekly and monthly medication audits were in place to monitor the safe use of medicines.

● A professional who had regular contact with the service advised that Island Court Care Home passed a recent external medication audit. The home was also in the process of moving to an electronic medication administration record system, which would further improve oversight of medicines.

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.

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.

● People did not always have capacity assessments completed when it was necessary to do so. We found people had capacity assessments in place for specific assessed needs, such as the use of bed rails or treatments such as chiropody. However, people's capacity to consent was not always considered and assessed when incidents had happened. This meant there was a risk that people's right to a private life could be infringed.
● Not all staff members had completed MCA and DoLS training. We found staff were not always knowledgeable about this subject. For example, staff we spoke with weren't able aware who was subject to a DoLS authorisation or what that meant for people.

The provider had failed to ensure people's rights were protected. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who were unable to consent to restrictions on their liberty had DoLS authorisations in place. Systems and processes were in place to track the progress of applications, when further authorisations were required and any conditions to the authorisation.
● People were free to access both floors of the home and the outside space. Some people had friendships

with people on both units and chose where in the home they wished to spend their time.

Staff support: induction, training, skills and experience
● Not all staff had received up to date training in a range of relevant subjects. For example, a significant proportion of the staff team had not completed infection control, safeguarding adults or prevention of falls training. This may have contributed to the lack of staff knowledge, such as the failure to recognise safeguarding matters. The registered manager advised that training figures were impacted by several new staff members who were still in their induction period.
● New staff members received an induction; staff files we reviewed showed inductions had been successfully completed.
● Competency assessments were carried out for moving and handling and medication administration. Where issues were identified in these areas, actions were taken to improve the staff member's knowledge and skills.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care plans and risk assessments were in place to detail people's specific needs and choices. Records showed that people's care plans were tailored to consider their person-centred needs. For example, where a person had a specific health need such as diabetes or epilepsy, care plans gave details to staff about how to monitor and support them.
● People had individual care plans and risk assessments to consider their oral health needs.

Supporting people to eat and drink enough to maintain a balanced diet
● Prior to the inspection we had received concerns that people weren't receiving enough to eat. When we visited the service, people spoke positively about the food and told us they were given choice. One person said, "We get a choice of two (options) at lunchtime. For breakfast you can have a full English or toast. They are good size portions."
● Care plans contained details about people who required specialist diets. Kitchen staff liaised regularly with the staff team to ensure they had up to date information about people's dietary needs. For example, some people required fortified diets, or had cultural dietary needs.
● Where people were at risk of malnutrition or dehydration, systems were in place to monitor intake and request external support as necessary.

Adapting service, design, decoration to meet people's needs
● Some people's doors were personalised; the registered manager advised that some people chose not to have any pictures or decorations on their door. The activity coordinator explained how they supported people to personalise their door or room if they wished.
● Communal areas had clear signage to help people to orientate around the home. For example, bathrooms and toilets had signs in place.
● The provider had adapted one communal area in the style of a café and bar. People could use these spaces as they wished and events were also held such as coffee mornings, or beer tasting. This supported people who weren't able to access the community to enjoy these pastimes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People and relatives said people were supported to access healthcare services as they needed. We reviewed documents which reflected that professionals were consulted and referrals were made when appropriate.
● A professional who regularly visited the home reported that the staff team were responsive to any

concerns and advice.

● Staff were knowledgeable about people's health needs and how to respond if a person displayed symptoms of a health condition. For example, staff understood how to support a person with epilepsy, should they experience a seizure.

● Records showed people had regular health appointments such as seeing an optician.

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 of this key question since this service registered. 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; Respecting and promoting people's privacy, dignity and independence

● During our inspection we observed several caring interactions between staff and people. However, a number of people told us there were inconsistencies in the caring attitude of staff. One person explained that on one occasion they had told a staff member they were struggling to breathe, but the staff member said they would be okay and left without providing any support. Another person said, "Some are (caring), some are standoffish. They have got their favourites. They don't say a lot to you."

● People were not always supported in a way that promoted their dignity. We observed one person was left in heavily soiled clothes for the majority of the day. On another occasion, we heard staff members using undignified language when interacting with a person. The staff members then went on to have a discussion together about the person's personal care, while they were supporting the person into a wheelchair in the communal lounge.

● During a mealtime, we observed a person in distress was ignored by four staff members in the same room, when the person repeatedly asked for help. Another carer then entered the room shortly afterwards and provided reassurance and support.

People did not always receive compassionate care that upheld their dignity. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's religious and cultural needs were considered and documented in their care plans. These considerations addressed both practical needs such as dietary requirements and wider cultural preferences such as specific activities a person enjoyed.

● The provider arranged for people to practice their religion both within the service and out in the community. There was a regular religious service conducted at the home for those who wished to attend.

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

● There was a system in place to review people's care plans. However, we received mixed feedback from people and relatives about whether they had seen their care plans or been involved in reviews. Some people and relatives reported being involved and updated, while others said they hadn't taken part in any discussions.

● Resident meetings took place for people to share their views. One person explained, "Yes we have them, we put forward any complaints and our views. They take notice of what you want."

● The provider had implemented a 'You said, we did' board in the entrance where it was detailed what

action had been taken in response to people's feedback. For example, a hot option was now provided for the evening meal.

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 of this key question since this service registered. This key question has been rated 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 spent long periods of time without engagement. During our inspection we noted that people were often left alone in communal areas without staff present. For example, we observed incidences of people requiring support but staff members were not available. We also found that people were left watching a sport on television that they were not interested in.
- There was an activity coordinator who attended the service on a part-time basis; the provider was in the process of recruiting a full-time staff member to this post. An activity board displayed planned activities for people and photographs throughout the service demonstrated occasions that people had celebrated at the home.
- Activities were organised for individuals and groups, taking into account people's preferences. For example, an outdoor activity had been modified to ensure a person who was cared for in bed could enjoy their preferred pastime. The activity coordinator had considered what activities appealed to different groups, as the male and female residents tended to enjoy different interests.
- People were encouraged and supported with activities in the community. Staff were facilitating trips to the local library for people.

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.

- Information wasn't always presented in a way to support people with cognitive impairments to make choices. For example, people were asked about meal choices, but no visual aids were on display to aid decision making. A staff member told us that sample plates were previously used to give people examples of options available, but this practice had now stopped.
- Care plans considered people's individual communication needs. For example, where people did not verbally communicate, there was guidance to support staff with communication.
- The registered manager understood the expectations of the Accessible Information Standard and was able to describe how this was achieved depending on a person's needs.
- The provider had two large multimedia screens which could be used to support communication in a number of ways. People could review their information in large print using these devices. They could also be utilised for video calls.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Where there were changes to a person's support needs following an incident, care plans did not always give clear instructions to staff about how to meet those needs. Staff we spoke with about a particular incident were unclear what measures were in place to keep the people safe.

● More generally, people's care plans and risk assessments contained person-centred information about their health and support needs. For example, one person had a particular preference about their routine that was detailed in their care plan. We observed staff supporting the person in line with their wishes.

● Staff were knowledgeable about people's likes, dislikes, needs and histories. However, we observed that staff practice did not always actively promote people's person-centred needs.

Improving care quality in response to complaints or concerns

● The provider sought feedback from people, relatives and professionals. Results from a recent questionnaire had been analysed and actions in relation to the findings were documented.

● The provider had a system in place to record, investigate and evaluate any complaints received. There was a monthly audit tool completed to oversee complaints received by the service.

End of life care and support

● People had care plans in place to consider their individual wishes, values and beliefs at the end of their lives.

● Those who were being supported with end of life care had advanced care plans in place. Records showed the service regularly liaised with medical professionals about those receiving this care, to ensure people were kept comfortable and their needs were met.

Requires Improvement

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. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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

- Quality assurance systems had failed to identify the areas of concern we highlighted during our inspection. Audits had not been effective in finding the issues we established in relation to the safety and quality of the service.
- The provider's processes were not effective in auditing accidents and incidents to identify potential trends. As a result, there was a failure to highlight any learning which could be taken forward to reduce incidents in the future.
- Systems which oversaw the culture of care at Island Court Care Home were not effective in driving high quality, compassionate care to service users. Some people reported a culture of favouritism from some staff towards people at the service. We observed that there was a culture of minimising the seriousness of incidents which led to a failure to take appropriate action.
- Governance systems failed to identify when capacity assessments were required as part of the response to an incident. This meant processes were not robust in ensuring the MCA was always complied with.
- Systems were not effective in ensuring allegations of abuse or improper treatment were robustly recorded, investigated and reported to external agencies as appropriate.
- Processes to monitor the dependency needs of the service did not reflect the feedback we consistently received from people and staff that more suitably qualified staff were required to meet people's needs.
- Governance systems were not established to identify issues the issues with staff practice that we observed during the inspection. This meant opportunities to improve the responsiveness of the service were not highlighted and actioned.

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) 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; Working in partnership with others

- People and relatives mostly knew who the registered manager was and what steps they would take to raise any issues they may have. However, some relatives reported difficulties in making contact with the home. One family member said, "I have given up trying to phone because I can never get through."

● Staff meetings and supervisions were held regularly. However, we received mixed feedback from staff about whether any issues they raised would be acted upon. One staff member said, "Somethings have been reported, but it falls on deaf ears." Another staff member told us, "You have to raise them a few times, but then they do change."
● We received mixed responses from professionals about how the home worked in partnership with other organisations. Professionals involved in people's health needs advised there was good communication and the service was responsive to advice. However, some professionals had concerns about how accidents and incidents were responded to and managed.
● Systems were established to seek feedback from people, families and visitors to the service. Results were analysed and actions taken to address the findings.
● Relatives commented positively about the atmosphere and their impressions of the service. The family members we spoke with felt the service was well managed.

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
● We identified that CQC had not been notified about several safeguarding incidents that had been raised with the Local Authority. The registered manager corrected this following the inspection.

Continuous learning and improving care
● Systems and processes were not always established to maintain oversight of the service and identify meaningful learning. This meant there were missed opportunities to drive improvements.
● Some people and staff reported a deterioration in the quality of the service. One person said, "It was beautiful when I decided to stay here, but it's gone from bad to worse." A staff member told us, "It used to be a happy home."

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 10 HSCA RA Regulations 2014 Dignity and respect People did not always receive compassionate care that upheld their dignity. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people's rights were protected. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to protect people through infection control practices and robust monitoring and management of risks. This put 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) Regulation 2014.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to take action to safeguard people from the risk of abuse. This included a failure to escalate concerns and take steps to minimise any ongoing risk to people. 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.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Impose a condition