Leaf Care Services Ltd

Ixworth Dementia Village

Inspection report

Ixworth Court
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Ixworth Dementia Village is a residential care home providing accommodation and personal care for up to 24 people. At the time of our inspection there were 23 people using the service most of whom were living with varying levels of dementia. The service consists of three houses (Mayfair, Homely and Traditional) which are all on the ground floor.

People's experience of using this service and what we found
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. When events or incidents had occurred, records did not evidence what action had been taken. There was no evidence lessons were learnt when things went wrong.

Infection control procedures were not always followed to ensure the spread of infection was reduced. There were safeguarding procedures in place however these were not always followed to ensure people were protected from potential harm. Peoples' medicines were not managed safely.
There were insufficient trained or supervised staff to safely meet the needs of people. There was limited support for people to avoid social isolation, follow interests and take part in activities.

The service was not consistently working within the principles of the Mental Capacity Act 2005 (MCA) People had not been supported to maximise their decision making and records lacked detail on the information used to determine people's capacity.

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

The registered manager had not been supported and enabled to have adequate oversight of the service. Quality assurance systems and processes did not identify or address all of the issues found during this inspection.

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 good

Why we inspected
The inspection was prompted in part due to significant concerns we found during an inspection of the other service run by this provider.

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 have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Following the inspection, the provider took steps to mitigate risks, such as undertaking the voluntary suspension on any new admissions and increasing the staffing levels. They also employed the services of a Health and Social Care Consultant to help them devise and work to an action plan to make the necessary improvements.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, medicines, consent procedures, staffing, nutrition, person-centred care, and governance at this inspection.

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 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. We will also request an action plan from the provider to understand what they will do to improve the standards of quality and safety.

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 effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
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**

Ixworth Dementia Village

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 carried out by three inspectors, on the first day. One of those inspectors specialised in medicines. On the second and third day of the inspection, two inspectors visited the service. The third inspection visit took place during the evening.

Service and service type
Ixworth Dementia Village 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. Ixworth Dementia Village is a care home without 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.

The nominated individual was present on the first two days we inspected. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was unannounced on all three days.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority. 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 with two people who used the service and four relatives about their experience of the care provided. We reviewed seven care plans and nine people's medicine administration records. We spoke with 18 members of staff which included care staff, the cook, the nominated individual, the registered manager, provider and two business support managers.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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.

Staffing and recruitment

● The number of staff at the service was not always sufficient to provide consistent, safe care for people. The provider had not ensured there were enough numbers of suitably competent and skilled staff deployed effectively to support people safely. A member of staff told us, "They don't use agency staff here. You just never know what you are going to find when you get here. Lack of staff is a big issue here. Weekends are always a problem…you come in some days and there are just two staff across two [houses]." Another staff member commented, "We don't have breaks [during particular shift]. We cannot go on breaks and leave our colleagues alone, it's just not safe."

● Staffing levels were not managed safely. There was no system or method in place to calculate safe staffing levels according to people's individual needs and risks. This meant there was no system to identify when staffing levels needed reviewing. One person's relative told us, "Staff are very busy, always rushing about no time to chat to people."

● Across all three days of our inspection we noted that people were not engaged in any meaningful activity by staff. Many people were disengaged or displayed distressed behaviours. We observed one person across both days of our inspection who mobilised around the service independently without staff support, and on one occasion they were not appropriately dressed. We alerted staff on two occasions that they were in need of assistance as the staff were busy assisting other people.

● Children under the age of 18 were working at the service. Two of these were through a college placement and one was an employed member of staff. National guidance clearly states that children under the age of 18 employed in care homes should not be working without an assessment of their competency and confidence to carry out all the tasks required of them. The provider had failed to implement this and the care worker and students under the age of 18 were providing direct care to people without the appropriate support and training.

The provider had failed to ensure there were sufficient numbers of suitably trained staff deployed in the service. This placed people at risk of harm and is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection we requested to view staff recruitment records. Not all of these were supplied to us when requested and the provider did not have a robust system for oversight. We therefore could not be assured that staff were safely recruited and had undertaken a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We have reported on this in the key question of 'Well-Led'.

Assessing risk, safety monitoring and management

● The provider failed to ensure people were protected from the risk of avoidable harm.

● Staff did not always support people to reposition, in line with their plan of care, when they were cared for in bed. This exposed them to the risk of developing a pressure ulcer.
● Where people became upset, agitated or distressed, and this posed a risk to themselves or others, there was a lack of guidance in care plans for staff to support the person or to deescalate the situation. This placed people at risk of harming themselves or other people around them.
● 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.
● Staff did not always effectively support people to eat and drink. Risk assessments on the risk of choking lacked detail and information needed to keep people safe. This exposed them to the risk of harm.
● The provider did not consistently ensure people had the right equipment they needed. People did not have access to a call bell in their bedroom. Three people told us they had to shout from their bedroom in order to seek staff assistance and they were often not heard when doing so. This exposed them to risk of social isolation, unmet care and emotional needs and physical discomfort.

Using medicines safely
● Procedures staff followed to support people with their medicines were unsafe and therefore people were at risk of medicine errors and not receiving their medicines in line with the prescriber's instructions.
● Medicines prescribed for external application such as creams and emollients were not being kept securely to ensure people could not access them or put themselves at risk of accidental harm. We also found that some medicines for external application had been opened and in use for longer than their expiry times.
● The safe storage arrangements for oral medicines were inadequate as medicines could be accessed by all members of staff and not only those trained and authorised to do so.
● The temperatures at which medicines requiring refrigeration were being stored had not recently been monitored and recorded on a daily basis. This meant there was a risk medicines that could be stored at specific low temperatures would not be effective.
● We found that the most recent medicine audit had been carried out two months previously and so not sufficiently frequent to identify the issues we raised about medicines during this inspection and to ensure the manager has adequate oversight of medicines at the service.

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

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. we continued to identify a shortfall in the availability of handwashing facilities. This was an issue we highlighted at the last inspection and one which had still not been rectified despite assurances from the provider that action had been taken to address this. We also found areas of the service with damaged flooring which would have made effective and hygienic cleaning impossible. We also found appliances in the one of the kitchens dirty and food in the fridge not dated. This increased the risk of infection.
● We were partially assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were partially 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.
● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

The provider was facilitating visits to people living at the service in accordance with current guidance.

Systems and processes to safeguard people from the risk of abuse
● There were indicators of a closed culture at the service where punitive measures were used to manage people's distressed behaviour. We reviewed daily notes and found that staff were potentially using restrictive interventions without appropriate care plans and authorisations.
● Several staff told us there was often a difficult atmosphere at the service, one where they didn't feel able to speak up or report concerns for fear of repercussions. This did not assure us that staff felt able to raise concerns, to keep people safe, in an open culture.

Learning lessons when things go wrong
● There was little evidence seen of learning lessons when things go wrong, and we found the provider reactive as opposed to learning and making improvements based on incidents.
● As concerns were not being identified by the provider or manager, there were no action plans in place identifying areas of improvement or where lessons could be learnt. When incidents had occurred in the home these were not reviewed to reduce the risk of reoccurrence.

Inadequate

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 deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
- We were not assured that people's nutritional needs were fully met.
- Records of food intake for people at risk of malnutrition or who were known to be losing weight were not always regularly completed. There was little evidence of people being offered fortified or healthy snacks throughout the day to increase their food intake.
- During the lunchtime meal, we observed that people were not offered any choice. The meal for everyone was sausages, chips and beans. When we raised this with a member of staff the option of broccoli was added. .
- The catering staff was not aware of people's dietary needs, including who was diabetic or who had any specialist support needs. This placed people at risk of receiving foods that could have compromised their dietary needs.
- Staff told us their concerns at the lack of food supplies towards the end of the week. . A member of staff commented, "There is not enough food. Every week we run out of things like bread and milk." They also stated the quality of the food was not always good with a reliance on frozen foods.

This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff had not received the support and training necessary to ensure they could be effective in their roles.
- Limited evidence of staff training was available during the inspection. Staff confirmed that they had not had any recent moving and handling training, fire safety, practical first aid or fire evacuation training. This meant people were at risk as staff did not always have the knowledge to support them effectively
- Ixworth Dementia Village is promoted as specialist dementia care. However, we found staff had not received training in best practice to support people living with dementia.
- We found staff who delivered care did not have the understanding or knowledge of restrictive practices, and we found restrictive practices were used by staff.

Staff lacked training and support in order to meet people's This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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.

● Some people were administered their medicines covertly without legal authorisation and without consultation with other health profe4ssionals in line with national guidance. Covertly means concealed in food or drink.
● People's consent to their care and treatment had not always been sought and recorded appropriately. Applications to deprive people of their liberty had not all been made appropriately for at least one person who required this.
● Where there were concerns about a person's capacity to consent to a particular decision, the MCA was not always followed. The capacity assessments completed were not clear; the outcome of the assessment had often been decided before the assessment had been completed and best interest decisions were not recorded with the involvement of relevant people.
● Following a period of distress and anxiety, resulting in some damage to their belongings, one person had the majority of their furniture and possessions removed from their bedroom. Whilst staff took this action to try and reduce damage, there was no best interest for the decision and no consideration as to whether this was the least restrictive option.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The environment needed improvement to ensure that good practice in guidance in dementia care was being followed. . There were walls and doors either plain white or heavily patterned at the service. We found several people seeking assistance and reassurance as they were unable to locate their own bedrooms and therefore navigate independently around the service.
● Areas of the service were in poor state of repair. The external grounds were not well maintained with uneven patio areas and gardens that had not been weeded or had the grass mown. A relative told us, "They could improve the outside space. The upkeep of the gardens is not great they need to invest in a gardener.
● Re-configuration of a part of the service was taking place. This had been to provide additional accommodation for 'live in carers' who stayed on site. This had reduced the window outlook available to people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Records in relation to people's day to day care were poor. They did not evidence that planned care was provided.

● Not all staff were trained to use the care planning system in place. This meant that not all staff were able to access important information about people's support needs and previous care that had taken place.
● Best practice guidance was not always referred to or used to increase the effectiveness of people's care. This included best practice guidance for people living with dementia.

Inadequate

Is the service caring?

Our findings

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.

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 deteriorated to Inadequate. This meant people were not always treated with compassion and there were breaches of dignity and shortfalls.

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; Respecting and promoting people's privacy, dignity and independence

- 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.
- People were not always supported with good personal care. Some people were wearing creased or stained clothing which was not respectful of their dignity.
- Due to the deployment of staff and lack of skills, we found people were not always engaged and stimulated. We observed people left unsupervised for long periods of time with no meaningful activities in place. We had to intervene and ask staff to support one person whose clothes were soiled and they were distressed.
- People had no access to call bells and therefore could not seek support of staff should they have needed to. We were told how people needed to shout staff for assistance which meant their support was often delayed as they were not heard. This was not respectful of their dignity.
- The provider's failure to maintain the environment and communal gardens following best practice in the care of people living with dementia, did not support people's right to live dignified lives.

People were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

- We also saw warm and caring relationships between staff and people. One person's family member said, "They need more staff, but the staff that here are excellent and know [family member' really well."

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 deteriorated to 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 as an effective care planning system was not in place.
- Not all care plans contained sufficient information to ensure staff knew how to deliver people's care in a safe and person-centred way. For example, a person with complex support needs did not have sufficient guidance for staff about how to support them to ensure theirs and others safety.
- People's care and support did not always take into account current legislation and consider relevant nationally recognised evidence-based guidance.
- There was evidence of some advanced care plans in place for some people, but these were not detailed. This information is important so that people's individual wishes are considered and planned for.

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.

- The service was not enabling for people who were living with dementia. Although they were promoted as a 'specialist dementia' service there was very limited signage to aid people in navigating around. Room numbers and names/photographs were in place for some people, but these were situated high up and in line with the top of the door which made them inaccessible and ineffective communication for most people.
- The menu for the week was written on a blackboard in the houses. This, however, included meals for the whole week in written format which was not enabling for people who would have benefitted from pictorial information.

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

- Care staff were responsible for facilitating activities for people however they were also providing care and support, helping with cleaning and laundry duty as well as some meal preparation. This means they did not have the time to support people to follow their interests and to take part in activities.
- The service was not pro-active in making sure people did not experience loneliness. People who spent their time in their bedrooms had little or no stimulation, only that from staff performing a care task. Coupled with the lack of call bell system that enabled people to seek staff assistance and company should they have wished for it meant people were at risk of social isolation.

Improving care quality in response to complaints or concerns

● There was a complaints procedure in place. We saw a record was kept of complaints but not always of the learning taken from them.

● We received mixed feedback from people living at the service and their relatives about their experiences of raising concerns. For example, one relative spoke of challenges with communication and that they have to be persistent in order for changes for their family member to be made. Two other relatives spoke of their satisfaction with the care their family member received and that they hadn't had a cause to raise a complaint.

● Not all people were clearly able to communication their wishes and feelings and systems to support them to raise any concerns or complaints should they have had any.

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 Good. 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; Continuous learning and improving care; Working in partnership with others

- The quality assurance systems were not robust. There was ineffective governance and poor oversight at regional manager and provider level which had failed to fully identify shortfalls in the service putting people at risk of harm.
- The provider had not demonstrated learning from feedback at a recent inspection at another location and similar concerns were found at Ixworth Dementia Village.
- The registered manager was not empowered to manage the service and to take decisions. For example, staffing rotas, were made off site by the providers human resources department and not on site by the registered manager who had the oversight of people's needs.
- The lack of staffing and the ineffective deployment of staff led to poor communication and outcomes for people. This was apparent in the delivery of care and in care plans such as pressure care, and nutritional and hydration risk where records did not demonstrate that people were receiving the care and support, they required.
- There were no systems in place to ensure people had their rights protected under the Mental Capacity Act.
- We could not be fully assured staff were safely recruited as we could not access all staff files to evidence this.

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

- The provider had failed to ensure people were receiving care that met their individual needs. Care plans were not consistent, accurate or kept up to date to give staff the instructions they needed to provide person centred care.
- We were not always assured that a positive, person-centred, inclusive approach to care was being achieved. A relative told us, "The telephone is never answered. No one answered the phone today. It's so frustrating."
- Areas of risk were not being effectively monitored and health and well-being of people living at the home was not routinely assessed.
- Many staff told us they felt unsupported and under-valued by the provider and felt their concerns were not listened to.

The service was not well led. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

● Duty of candour was not always fulfilled. We were concerned that the provider was not always open and honest with the inspection team. During this inspection we found that records we requested to view were being amended and updated before being shared with us. This included a member of staff updating and changing care records at 3am and another document being backdated before being given to us.

● We also found, during the first day of our inspection, additional staff were brought in to increase the numbers at work. Staff told us this was not reflective of a usual shift and that the staff had been called in because of the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not being supported effectively to help them to eat and drink enough

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 11 HSCA RA Regulations 2014 Need for consent The provider did not always ensure consent to care and treatment was sought in line with legislation and guidance

The enforcement action we took:

Notice of Decision to cancel the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to have systems place or robust enough to demonstrate safety was well managed and risks were mitigated. The provider failed to ensure the proper and safe management of medicines was in place.

The enforcement action we took:

Notice of Decision to cancel the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to demonstrate effective governance, including assurance and auditing systems or processes

The enforcement action we took:

Notice of Decision to cancel the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not always available to meet people's care and support needs.

Staff lacked competency and support in order to meet peoples' needs and assess and mitigate known risks to people.

The enforcement action we took:

Notice of Decision to cancel the location