Premier Nursing Homes Limited

Beechwood Care Home

Inspection report

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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
Beechwood Care Home is a nursing home providing personal and nursing care to up to 60 older people, some of whom may be living with a dementia. At the time of our inspection there were 40 people using the service. The home has two units. The ground floor unit is for people who require residential care and the first-floor unit provides nursing care.

People's experience of using this service and what we found
The service was not safe. Risk assessment were either not in place or were not accurate. Monitoring records had not been completed consistently and we could not be assured people were receiving appropriate care and support.

Medicines had not been managed, stored or administered safely. Insufficient systems to monitor medicines had resulted in numerous medicine errors.

People did not receive appropriate support with meals and had not been provided with enough to drink to maintain their health. Timely action had not always been taken where people had begun to lose weight.

Staff were unfamiliar with people's needs and care records were not up to date. This had caused delays with treatment and a lack of person-centred support being provided.

Communication between staff and people was poor and people were not treated with dignity and respect. Support provided to staff was inconsistent and the provider had failed to ensure staff training was up to date.

There was a significant lack of provider oversight. The quality assurance processes in place were not effective and failed to identify and address shortfalls in a timely manner. Complaints had not always been investigated thoroughly.

People were not supported to have maximum choice and control of their lives and staff did not always 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.

Safe recruitment processes had been followed and people told us they felt safe living at the service.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 31 July 2020)

The provider completed an action plan after the last comprehensive inspection in September 2019.

A further focused inspection took place in July 2020. However, not all the breaches identified in the September 2019 inspection were reviewed at this inspection and therefore some of the breaches still remained.

At this inspection we reviewed the remaining breaches found during the inspection in September 2019. We found the provider remained in breach of these regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the quality of care being provided to people and staffing levels. 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 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.

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

The provider acknowledged the significant shortfalls found during this inspection. They took action following the first day of inspection to begin to address some of the shortfalls found. They produced an action plan and began to work with the local authority to make improvements.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

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

We have identified breaches in relation to person-centred care, dignity and respect, assessing and managing risks, medicine management, infection control, staff training and support and provider oversight and monitoring 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 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 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**

Beechwood 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.

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 undertaken by two inspectors on the first and second days of inspection. The third day of inspection was undertaken by a medicine inspector. An Expert by Experience made calls to people and relatives following the site visits. 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
Beechwood 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. Beechwood 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 not a registered manager in post. The previous registered manager was now a regional manager and was still supporting the home alongside a newly recruited senior home manager. There had been no registered manager in post since March 2022.

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 other professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We contacted five people who used the service and ten relatives to ask about their experience of the care provided. Of the five people and ten relatives contacted, two people and seven relatives provided feedback. We spoke with fourteen members of staff including the divisional director, two regional managers, senior care home manager, interim clinical lead, two nurses, senior carer, carers, domestic assistant and activities coordinator. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We conducted a tour of the service and looked at a wide variety of records. These included multiple care and medicine records, monitoring documentation, staff files and audits used to monitor the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to 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

- Risks to people were not assessed and recorded appropriately. Thorough plans were not in place for areas such as skin integrity which had resulted in delays in appropriate support being provided. This had resulted in a decline in people's health.
- Risk assessment had not been updated following changes in people's care and support needs or medical conditions. Monitoring records had not been consistently completed to evidence that people's needs were being met with regards to repositioning and fluid intake.
- When accidents and incidents had occurred, people's risk assessments had not been updated to reduce the risk of reoccurrence. The manager did not have effective oversight of accidents and incidents which meant appropriate action had not always been taken in response to risks.
- Due to the high use of agency staff, staff were not always aware of risks to people and how these were to be managed. Records in place did not contain the most up to date, accurate information which placed people at increased risk of harm.

Failure to assess, monitor and mitigate risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines had not been stored, recorded or administered safely. This had resulted in people suffering harm.
- Medicine records were inaccurate and prescriber instructions had not always been followed. We could not be assured people had received their medicines as prescribed. For example, one person refused to have their pain patch medicine changed. Staff had not made any further attempt to change the patch. This resulted in a person being without pain medication for a seven-day period.
- We found examples where people had received an overdose of their medication due to inaccurate records.

Failure to ensure the proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action during the first day of inspection to address the medicine shortfalls. A full audit was completed, and support was requested from other professionals to ensure medicine management was safe.

Preventing and controlling infection

- We were not assured that the provider was preventing visitors from catching and spreading infections.

Thorough checks were not completed when visitors entered the home.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. There had been no recent IPC audits completed.
● We were somewhat assured that the provider was using PPE effectively and safely. PPE was not always available or disposed of appropriately.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was a strong malodour on day two of the inspection and no domestic staff were not duty.
● 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 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.

Failure to operate effective infection, prevention and control to reduce the risk of spreading infections is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● Visits to Beechwood Care Home were in line with government guidelines. No restrictions were in place and visits took place during the inspection process.

Staffing and recruitment
● There was a high use of agency staff within the service. Agency profiles did not always contain sufficient information. Agency profiles were not available for some agency staff on duty at the time of this inspection
● Appropriate identification checks had not always been completed with regards to agency staff. One agency staff member told us, "This is the first time I have worked here. No one checked my ID when I arrived, and I have had no induction."
● People, relatives and staff told us they had concerns over the high number of agency staff working in the service. On the second day of inspection, there was only one employed member of staff on duty on the nursing unit, along with three agency care assistants and two agency nurses. Observations and discussions with agency staff evidenced they were not familiar with people or their support needs.

Failure to deploy a sufficient number of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment processes had been followed for staff employed by the provider. Appropriate pre-employment checks had been completed.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to safeguard people from the risk of abuse. These had not always been followed.
● A number of safeguarding concerns were subsequently raised by the provider following this inspection. The provider was open and honest about the shortfalls found.
● People and relatives said they felt safe living at the service. Comments included, "I think it is a safe place. I have no problems or issues with safety in this home" and "[Person's name] is very safe, I have no concerns. All doors are locked with codes so that offers me reassurance."

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were provided with the skilled, knowledge and experience to carry out their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvements had been made and the provider was still in beach of regulation 18.

● Staff had not been provided with regular training to ensure their skills and knowledge was maintained. For example, only 46% of staff had up to date nutrition training and only 39% had up to date safeguarding training.
● Sufficient support had not been provided to staff. Regular one to one supervision had not been completed consistently, with some staff not being provided with any supervision for over six months.
● The induction for agency staff was insufficient. Agency staff told us they had commenced their first shift at the service without any induction being provided.

Failure to provide staff with effective and sufficient supervision and training to enable them to carry out their roles was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Pre-admission assessments had taken place to ensure the service could meet people's needs but care plans were either not always in place or had not been updated to reflect people's current care and support needs.

Failure to ensure maintain accurate, complete and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
● People did not receive effective support to maintain a balanced diet.
● People were not always provided with sufficient fluids. Daily fluid targets were not always recorded. Where people had specific medical conditions, which meant they needed a specified amount of fluid, these had

not been met. Drinking cups and jugs in people's bedrooms were visibly dirty.
● People had not been consistently weighed to monitor their health. Where weight loss had occurred, timely action had not been taken to seek support from professionals.

Failure to meet people's nutritional and hydration needs was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care
● Professionals had not always been contacted in a timely manner to ensure people's care and support met their needs. For example, professionals reported delays with urine samples being obtained or skin integrity issues being reported.
● Where professional advice had been provided, this had not always been followed by staff. For example, where professionals had requested people's periods of distress or anxiety were recorded this had not always been completed.
● Prior to this inspection, professionals raised concerns that staff were not familiar with people's care and support needs which had resulted in delays with treatment.

Failure to actively work with other professionals to ensure care and treatment remains appropriate and safe was a breach of Regulation 12 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.
● The principles of the MCA were not always followed. Where people lacked capacity, appropriate best interest decision had been recorded. These did not always include the relevant people.
● Appropriate records were not available to evidence where people had Lasting Power Attorneys in place.
● DoLS applications had been submitted where required.

We recommend the provider considers best practice guidance in relation the Mental Capacity Act 2005 and updates there practice accordingly.

Adapting service, design, decoration to meet people's needs
● The environment within the home was appropriately designed to meet people's needs. Where required, appropriate aids were in place to support people with cognitive impairments.
● People had the option to personalise their bedrooms. Ample communal areas were available as well as outdoor space for people to enjoy.

- There were some areas of the service that required additional maintenance or in need of repair.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls

Ensuring people are well treated and supported; respecting equality and diversity
- Staff were not attentive to people's needs. The high use of agency staff resulted in staff being task orientated as they were unfamiliar with people's history. Staff told us they did not have time to engage in meaningful interactions with people.
- Communication between people and staff was poor. No conversations took place before support was provided. Staff were observed in communal spaces and did not interact with people.
- People were not supported in line with their care plans. This caused people to become distressed or disengaged.
- We highlighted these concerns to the senior management team during the first day of inspection who then conducted observations of interactions. They acknowledge the culture of the staff needed to improve.

Failure to communicate effectively with people and respect their preference is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
- People were not supported to express their views.
- Observation showed that choice was not offered to allow people to make their own decisions. For example, at mealtimes or when providing refreshments, no choice was offered.

Respecting and promoting people's privacy, dignity and independence
- People's privacy, dignity and independence was not always respected or promoted.
- The communal toilets on the nursing floor were locked during the morning of the first day of inspection which meant people were not able to access them independently.
- Where people would have benefited from additional aids or support with meals to promote independence, this was not provided.

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 requires improvement. The rating for this key question has remained 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

At the last comprehensive inspection in July 2019 the provider failed to ensure person-centred care was provided which reflected people's preferences and meet their needs. This was a breach of Regulation 9, (Person-centred care), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was not reviewed during the inspection in July 2020.

Not enough improvements had been made and the provider is still in breach of Regulation 9.

- Care plans had not always been updated when changes had occurred. For example, where people's mobility or skin integrity had deteriorated, care plans had not been updated to reflect this.
- Due to the high use of agency, not all staff were familiar with people's care and support needs. This resulted in people's needs not being met. One member of staff told us, "I don't always have time to support people in a person-centred way. Because agency staff don't know people, I have to keep checking what they are doing. I am always rushed."
- Daily 'flash meetings' had been introduced to ensure important information was handed over to senior staff on duty. However, these had not taken place consistently.

Failure to provide person-centred care to reflect people's preferences and meet their needs is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- Care plans provided some information with regards to people's communication needs. These had not always been followed. For example, one person required the use of hearing aids, but staff were not consistently ensuring these were worn.
- Information was not always present in a way people could understand. For example, picture menus were not used to aid decision regarding meal choices.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

● People were not always supported to follow their interests or take part in activities. One the second day of inspection no activities were on offer and we observed a lack of stimulation throughout the inspection.

● A part time activities coordinator was employed. However, there was no activity plan in place. Records of activities that people had participated in were inconsistent. One relative told us, "I have no idea what activities are on offer as there is never anything on the notice board to inform us. Communication between staff and myself is not the best."

● Relatives we able to visit the service when they wished. Visits could take place in people's bedrooms or in communal spaces.

Improving care quality in response to complaints or concerns

● The providers complaints policy had not always been followed. We found one example where a thorough response to concerns raised had not been provided. The provider was aware of this and action had been taken to address this.

● People and relatives told us if they had any concerns, they would raise this with the manager. However, they were unsure who the manager was.

End of life care and support

● People had end of life care plans in place, but these only contained basic information.

● Staff raised concerns that end of life care was not always provided to a high standard. One member of staff told us, "There has been issues with end of life medicines previously which caused an unnecessary delay."

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

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

- The quality assurance processes in place were not effective and failed to identify and address shortfalls in a timely manner.
- Where shortfalls had been identified, timescales for ensuring these shortfalls were actioned were not sufficient. Some shortfalls had been signed off as completed. However, they remained outstanding at the time of this inspection.
- The provider had failed to ensure they had effective oversight of the service. Some provider audits were incomplete and did not cover all expected areas.
- The provider failed to ensure regulatory requirements were being met and that people were provided with the expected level of care. Breaches remained at this inspection.

Failure to operate effective systems and process to assess, monitor and improve the service is a breach of Regulation 17 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

- There had been very little engagement with people and staff. The last staff survey had been completed in May 2021 where staff raised concerns that they didn't have enough time to provide adequate care to people. This concern remained at this inspection. There had been no recent engagement with people or their relatives.
- Professionals had raised concerns that timely action was not always taken to consult with appropriate professionals or following guidance provided. When assessments had taken place, staff were not always familiar with people and were therefore unable to provide the relevant information needed.

Failure to seek and act on feedback to continuously improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were able to maintain contact with their friends and relatives via visiting and telephone.

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

- The culture of the service was poor. Staff told us they had identified concerns with the previous manager

but had failed to escalate these to senior management.
● There was a clear lack of person-centred support being provided to people. This resulted in poor outcomes for people.

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 management team were open and honest throughout the inspection. The senior manager's present during the inspection agreed with the shortfalls found.
● The provider had plans in place to communicate with people and relatives about the inspection findings and action they were going to take to improve the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider failed to provide person-centred care to reflect people's preferences and meet their needs. 9(a)(b)

The enforcement action we took:

We took enforcement action but during the appeals and representations process a decision was made that this action did not proceed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider failed to communicate effectively with people and respect their preference. 10(1)

The enforcement action we took:

We took enforcement action but during the appeals and representations process a decision was made that this action did not proceed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to assess, monitor and mitigate risks to people. The provider failed to ensure the proper and safe management of medicines. The provider failed to operate effective infection, prevention and control measures to reduce the risk of spreading infections. 12(1)(2)(a)(b)(g)(h)

The enforcement action we took:

We took enforcement action but during the appeals and representations process a decision was made that

this action did not proceed.

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 failed to ensure systems and process were established and operated effectively to monitor and improve the service. The provider failed to assess, monitor and improve the service and mitigate risks. The provider failed to maintain accurate, complete and contemporaneous records. The provider failed to seek and action on feedback provided. 17((1)(2)(a)(b)(c)(e)

The enforcement action we took:

We took enforcement action but during the appeals and representations process a decision was made that this action did not proceed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to provide staff with effective and sufficient supervision and training to enable them to carry out their roles. 18(2)(a)

The enforcement action we took:

We took enforcement action but during the appeals and representations process a decision was made that this action did not proceed.