Southwinds Limited

Southwinds

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 4 May 2017. The service was registered to provide accommodation for up to 25 people. At the time of our inspection, 13 people with learning disabilities were using the service.

At our last comprehensive inspection on 1 December 2016, the provider was placed into special measures by CQC following an inadequate rating. The overall rating for the service remains 'Inadequate' and therefore remains in 'special 'measures.' This inspection found that there were not enough improvements to take the provider out of special measures. CQC is now considering the appropriate regulatory response.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last comprehensive inspection, the provider was in breach of seven regulations. Fire safety procedures were not followed; people were living in an environment that had unpleasant odours; people's health care needs were not responded to in a timely manner; their dignity was not promoted; care was not individual to people; the management was ineffective and they had not notified us about incidents when needed. We took enforcement action against the provider and they sent us an action plan on 4 January 2017 telling us how they would make improvements in these areas.

At this inspection, we found that the provider had completed some of these actions, but others were still outstanding. For example, few improvements had been made in relation to the individual and person centred nature of the support people received. In addition, whilst the audit system in place had been effective in relation to fire safety and the environment, and policies had been updated, the provider did not know what some of the policies were, and was not analysing the information gathered.

At our previous inspection, we also found that improvements were needed in various other aspects of the service. We were not confident that there were enough staff available for people during the night; staff did not have personal protective equipment readily available to them; the provider had not responded to safeguarding concerns as they should have done; risks to individuals were not managed. In addition, the provider did not understand or follow guidance when people were not able to make decisions for themselves; people did not have easy access to drinks and they were not supported to make choices about their meals. We also found that people were not actively involved in making decisions about their care; they had limited involvement with the planning of their support; opportunities to participate in meaningful activities were limited; care records did not contain the information staff needed and these were not accessible when staff needed to look at them.

At this inspection, we found that some improvements had been made, however further were required.

Risks to people were still not effectively assessed, monitored and reviewed. Staff were aware of how to safeguard people, but the provider still had not acted on concerns raised. Some staff were not aware of people's specific health conditions. The provider had still not followed guidance when people were not able to make decisions for themselves. Risks to people when eating were not managed, and people's choices and preferences were not considered.

People's independence was not promoted and they were not enabled to make decisions about their care. People did not receive care that was individual to them or person centred. People's care plans were being updated, but it was not clear how they had been involved with this. Care plans did not contain all the information that was important to people. When care plans were clear about the support people should receive, this was not always followed by staff.

The provider did not manage the service effectively to ensure that people received high quality care. They did not have effective systems in place to drive continuous improvements. They were unaware of the policies they had introduced. The overall culture of the service did not empower the people living there and the provider had failed to meet their legal obligations when things had gone wrong in the service.

The provider had made improvements to the environment, and fire safety procedures were followed. The provider had considered access to staff during the night, and medicines were administered safely. People received support from healthcare professionals, and their privacy was respected. People were able to maintain family relationships and said they would speak to staff if they had any problems.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people were not effectively assessed, monitored and reviewed. Staff were aware of how to safeguard people, but we were not confident the provider would act upon concerns raised. The provider had made improvements to the environment, and fire safety procedures were followed. The provider had considered access to staff during the night, and medicines were administered safely.

Is the service effective?

Inadequate

The service was not effective.

People received support from healthcare professionals, but some staff were not aware of people's specific conditions. The provider had not followed guidance when people were not able to make decisions for themselves. Risks to people when eating were not managed, and people's choices and preferences were not considered.

Is the service caring?

Requires Improvement

The service was not always caring.

People's independence was not promoted and they were not enabled to make decisions about their care. Their privacy was respected and people were able to maintain family relationships.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was individual to them or person centred. People's care plans were being updated, but it was not clear how people had been involved with this. Care plans did not contain all the information that was important to people. People said they would speak to staff if they had any problems.

Is the service well-led?

Inadequate

The service was not well led.

We continue to lack confidence in the provider. They have consistently not met the fundamental standards of care that people should expect to receive. They did not have effective systems in place to drive continuous improvements. They were unaware of the policies they had introduced. The overall culture of the service did not empower the people living there. The provider had failed to meet their legal obligations when things had gone wrong in the service.

Southwinds

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 4 May 2017 and was unannounced. The inspection team consisted of two inspectors.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also received current monitoring information from the local authority and healthcare professionals. We used this information to formulate our inspection plan.

We also had a provider information return (PIR) sent to us. A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. As part of our planning, we reviewed the information in the PIR.

We spoke with five people who used the service, two members of care staff, the deputy manager and the registered manager. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas. We also spoke with three visiting community professionals.

We looked at the care plans of five people to see if they were accurate and up to date. We also looked at records that related to the management of the service. This included the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fire safety procedures were not followed to ensure people's safety. At this inspection, we found the required improvements had been made in this area. We saw that staff followed guidance in relation to the fire doors. The fire service had also been out to the home and completed a fire safety check and further training had been carried out with the staff. Staff we spoke with were aware of the importance of following fire safety guidance.

The provider had also been in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were living in an environment that had unpleasant odours. At this inspection, we found that improvements had been made. The carpets had been cleaned, and even though we found there was still a lingering smell, this was not as offensive as previously noted.

We also reported that staff did not have access to personal protective equipment when needed. At this inspection, we found that gloves and aprons were available for staff to use when needed.

At our previous inspection, we reported that we were not confident the staffing levels were sufficient to meet the needs of people during the night. At this inspection, the provider had not increased the staffing levels, and the numbers of people who used the service had remained the same. However, the provider had considered how the one staff member who was awake during the night could alert the other staff member who was asleep in case of an emergency. We were not made aware of any incidents that had occurred during the night where people were potentially at risk as had happened previously. We could therefore not ascertain if these arrangements were suitably effective.

Although we saw improvements in these areas, at this inspection we found there were further areas of improvement required.

Risks to people were not effectively managed. We saw that some people were unsteady when walking. One person used the furniture to assist them. We checked the information in their care plan, and this stated that they should walk round the home holding onto rails as these gave them confidence and support. Staff confirmed that there were no rails for the person to use. The care plan also stated that to ensure they were not at risk of falling; they should walk with a member of staff and be observed. One of the person's dislikes was recorded as, 'Not being able to hold someone's hand when walking.' We saw them walking along the corridor by themselves, using the wall for support. One staff member told us, "We don't need to watch this person all the time when going from room to room." This meant the person was not able to use equipment that was recommended, and staff did not follow the guidance as outlined in their care plan.

Some people who used the service were diagnosed as having epilepsy. We checked to see how risks associated with seizures were managed. One person did not have a support plan in place regarding their epilepsy. There was no information that described to staff what this person's seizures would look like. The risk assessment in place stated that if they 'displayed any signs of fitting, staff should keep them safe and

call 999 immediately.' It did not state how long the seizure should continue for, the intensity, and did not give staff the information they needed to keep the person safe. One community professional reported to us, "Despite requesting that people's epilepsy care plans are individual to each person, this is still not the case." This meant that staff did not have clear guidance to follow to recognise the different types of seizures people could experience, and therefore this risk might not be effectively managed.

We saw that on two occasions, one person had been found on the floor by their bed. The records we looked at stated that one of these times, the staff member had heard a 'loud bang' and had then gone to the bedroom to see what had happened. They assisted the person back into bed after not finding any obvious injury. After these two incidents, no actions were taken to prevent this from happening in the future. The deputy manager told us, "We don't know if they fell or what happened." The provider had not followed this up or considered what the potential risks were for this person.

The above issues demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we reported that even though staff were aware of to how to raise safeguarding concerns, we were not confident that incidents had been reported when concerns were raised. At this inspection, we found that this was still the case. During our visit, we observed one person eating food that was considered to be high risk to them. We asked the provider to raise a safeguarding concern. At the time of issuing the draft report on 30 May 2017, the provider had not done this. Records also showed that one person had sustained a bruise to their left arm. No accident or incident form had been completed, and no safeguarding concern had been raised. This meant we could not be sure that all incidents were responded to correctly and people would be protected from harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take their medicines as prescribed. We observed staff stay with people to ensure they had taken their medicines, and people were offered a drink. We saw that medicines were stored safely to minimise the risks associated with them. When people had medicines prescribed 'when needed' rather than every day, we saw the provider had protocols in place to ensure this was administered correctly.

Inadequate

Is the service effective?

Our findings

At our previous inspection, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not responded to people's changing healthcare needs in a timely manner. At this inspection, we found that some improvements had been made, but further were required. One community professional told us, "The provider will ring up more now if they have concerns about someone." We saw that people were receiving support from the district nursing team, and that people had attended healthcare appointments. One person's health needs had changed significantly, and we saw their care plan was updated to reflect these changes. However, not all staff were aware about their health condition, what the risks were and what they should do if there was a problem. This meant that the person was at risk because healthcare needs may not have been responded to in a timely manner.

We also found improvements were needed as the provider was not acting within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack capacity to make particular decisions, any made on their behalf must be in their best interests and 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. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

At this inspection, we found that no improvements had been made. The provider told us that some people who used the service were not able to make certain decisions for themselves. When this was the case, they had still not assessed people's capacity to make specific decisions. We saw that the provider had made some decisions for people without assessing their capacity first. For example, one record stated, 'Because of my disability, [name of provider] looks after my finances.' It was not clear why this was in the person's best interests or who had been consulted about this decision. The provider had asked people they believed lacked capacity, to sign their care plans. They had made a DoLS application to the relevant authority without first determining if the person lacked capacity. Since out first new approach comprehensive inspection was completed in March 2015, the provider has consistently fallen below the standards expected with regards to acting in accordance with the MCA, and has failed to show an understanding about this legislation.

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

At our last inspection, we also found that improvements were needed to ensure that people had easier access to drinks. The provider had placed jugs and juice bottles on the sideboards in both lounges. In one lounge, we did not observe anyone helping themselves to a drink. We did see that people were offered a cold drink prior to their breakfast. However, people's preferences and choices were not always taken into account. We observed one person asking for a cup of tea. The staff member left the room, and on returning,

offered them a drink of juice. After a long pause, and a verbal prompt from the staff member, they agreed to a drink of juice. They then waited nearly an hour to have a cup of tea. One community professional told us, "I know that one person's preference is a hot drink without too much milk. They have told me that they have luke warm, milky drinks. The reason being is that it's then easier to drink." People told us that drinks were available at set times of the day. One person said, "We have tea in a morning, and then coffee at 11:00am." When we asked one person what they would do if they wanted another drink, they replied, "I don't know."

At our last inspection, we found that improvements were also needed to enable people to be actively involved in making decisions about their meals. We asked people what they were having to eat at lunchtime, and one person said, "I don't know. I have what comes." There was a written menu on the table. When asked about their lunch, another person picked this up, looked at it and said, "I don't know; I can't read what it says." At a previous inspection in March 2016, we had been told that accessible, picture menus were being considered. We found these were still not in place. Another person commented, "We don't know what's [for meals] tomorrow until it comes." We observed the lunchtime meal, and in one dining area, meals were plated up in the kitchen, all with gravy and no different sized portions. One person said, "I don't like sausages." The staff member told them that this was what they had chosen the day before and that they should try it. At the end of the meal, they had left both sausages on their plate, and were not offered an alternative. Their care records stated that they didn't like sausages. This demonstrated that people's choices were not always listened to.

Some people were at risk of choking, and the speech and language therapist had put recommendations for staff to follow regarding managing risks when eating. For one person this stated that staff should always be present, and the person should have a drink of water when eating. The staff member in the room did not observe them, and the person was only offered a drink after they had finished eating. We saw that they ate their food very quickly, and did not take time to swallow between mouthfuls. This person ate sausages for their meal. The speech and language therapist had identified these were a high risk food, and should only be given if they were tinned ones that were mashed well. Staff confirmed that these were the same 'normal' sausages that everyone else had eaten. This meant that the risks when eating were not managed, and there was a high risk of that person choking.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received training to support them in their roles. However, this was not demonstrated because people did not always receive care that was based on best practice. Staff were not skilled to recognise poor practice; for example, in not enabling choice and consent.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's dignity was not always promoted. At this inspection, we found that some improvements had been made, but further were required. People were treated with more dignity and respect. The provider had placed toilet paper in the bathrooms, and we saw people had clean clothes to wear.

However, people's independence was not promoted. One person told us, "The staff always bring my breakfast to me on the tray." We saw that milk had been added to their cereals, their toast was buttered, and their drink was prepared. This person was able to go out independently and also used public transport, which indicated that they would have the skills to prepare breakfast themselves. When we arrived at the home, the front door was locked, and one person stood in the porch whilst they waited for a staff member to come. This person told us, "I don't know how to unlock it. We have to wait for [Name of the provider]." They told us that in the past they had been able to open the front door themselves. This demonstrated that staff did not always support people to be independent.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that people were not actively involved in making decisions about their care. At this inspection, we found that improvements had not been made. People told us that there were set days for certain activities, such as baths or changing beds. Community professionals told us that the running of the home was still based on the routines that were in place, and that little had changed over time, and that choices for people were limited.

People's privacy was respected, and we observed staff support people in a discreet manner. People told us the staff spoke to them in a kind way. One person said, "The staff look after me." People were able to maintain family relationships that were important to them, and their families were encouraged to visit.

Inadequate

Is the service responsive?

Our findings

People did not receive care that was individual to them or empowered them to be in control of their lives. Most people living at Southwinds had been there for many years, and carried out their daily routines as they had always done. People told us they always did certain things on certain days. We saw that people continued to sit in the same rooms, usually in the same places, doing the same (or similar) things. People told us they were happy, but given the nature of their disabilities, they may not have fully understood that their lives did not have to be as routine. When asked about the person centred care that people received, one community professional told us, "After years of queries raised, and support we have given, nothing has changed. It is like a little institution." Another community professional commented, "They just don't get it; if they haven't got it by now, how will they in the future?"

When we observed the lunchtime meal, in one room, the food was brought to the table in serving dishes from the kitchen by staff. The people sitting at the table looked at these, but until they were prompted to help themselves, they did not. One staff member told us, "It's the first time we have used these dishes. It's all about being more person centred. This is new to all of us." People again had to be prompted to help themselves to drinks and second helpings. The provider told us how they had invited a speaker the previous week to give them advice on promoting person centred care for people. We saw this had only recently happened when this way of working with adults with learning disabilities has been promoted for many years. Feedback from community professionals was that little had changed for people who used the service. One community professional told us, "I've noticed today there's a hive of activity; whenever I've come before, everything has been the same."

The provider viewed some people as being independent in managing aspects of their care. However, we observed one person arrive for breakfast wearing dirty, stained trousers. This indicated that they might have needed more support to make informed choices when they got dressed. They changed their clothes later, but the two members of staff on duty earlier had been involved in other activities, and would not have been available to help them if needed. This demonstrated that people did not always receive support that was responsive to their needs.

We saw that people's care plans had been updated, and did contain some information that were personal to people. However, it was not at all clear how people had been involved with this process. Some people had been asked to sign the plans and the provider told us that they would not have understood the content. There were few pictorial images or different formats used to enable people to understand their plans. The local authority had reported in March 2017 that 'a detailed, person centred approach to all areas of assessed need is further recommended.' One community professional commented, "The standard of care planning is an ongoing saga." We saw that when the care plans contained specific information on how people should be supported, these were not always followed.

We saw care plans did not contain information about people's sexuality or personal relationships. Reference was made throughout one care plan that a person could become anxious. There was no support plan to give guidance to staff on how this person's anxiety should be managed. The only guidance stated, was for

staff to 'give reassurance.' There were no details as to how staff should do this, or what would work best for the individual. A community professional told us, "One person has [a certain health condition], and the guidance is to give a specific diet; but the plan doesn't stipulate what this should be." This meant that staff would not have the information needed to give them guidance to provide individualised care.

People were supported to take part in some activities they enjoyed or were of interest to them. Three people tended the garden on the morning of our inspection visit. One person told us, "I have been doing some weeding, I like being in the garden." Another person said, "I enjoyed that; I haven't done that for a long time." However, we were told that people did not always do things that they would have liked. One person said, "I used to watch [name of a certain programme]; I used to like that. I don't know why I don't watch it anymore." We observed people looking at photographs of people who they had known. Staff interacted with them while this was happening. A community professional commented, "I have never seen that before."

The above issues demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had the opportunity to attend meetings at the home, and told us that if they had any complaints they would speak with the staff. There had been no complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. They had not notified us of significant events they were required to report. At this inspection, the required improvements had been made, and they had sent us these notifications.

We had also found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was not well led, and the management and leadership in place were not effective. At this inspection, we found that all the required improvements had not been made. This is our sixth inspection since March 2015, and the provider has consistently not met the fundamental standards of care that people should expect to receive. Feedback that we have received from other organisations is that they, like us, do not have confidence in the providers' ability to provide care that is consistently safe, effective, caring, responsive and well led.

We found that the audit systems in place were not consistently effective. Information was being gathered, but there were not always actions in place to prevent incidents re-occurring. The information was not analysed and trends and themes were not identified. The audits were not used to drive improvements for the people who used the service. For example, the two incidents when one person had been found on the floor in their room were recorded, but no analysis of this happened and no action had been taken; information about the activities people did was listed, but not analysed or reflected on; when people were not receiving support as stated in the care plan, no actions had been taken to rectify this.

The provider had completed the PIR as requested, but when asked for some further detail about information they had included, they were unable to give this to us. For example, they had stated that certain policies were in place. When asked about these and how they were put into practice, they were not able to say, and told us that they had not read the policy that they said they had introduced.

The provider had engaged the services of an independent consultant since our last inspection. Information had been shared with us about the improvements they felt had been made but it was not clear how involved the provider had been with this. The culture of the service has not changed, it was still institutional, and not person centred. There had been few improvements as far as the experiences for people using the service were concerned. The provider has told us that they have brought in certain changes 'for CQC', rather than considering the improvements were needed to improve the lives of the people that used the service.

These issues all constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, in a letter dated 20 December 2016, the provider told us that an up to date policy had been put into place regarding their duty of candour. Our duty of candour regulation sets out some specific requirements that the provider must follow when things go wrong for people who use the service. The provider had not followed any of these specific requirements when a notifiable safety incident happened prior to our last inspection. Despite being asked if they had followed these requirements, at this inspection,

the provider had still not taken the required actions.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the home. However, despite having their web site updated in January 2017, they did not display their rating. The provider has since removed their website from the internet.

This was a breach of Regulation 20A 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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had ensured that the care and treatment of service users was appropriate, met their needs, or reflected their preferences. Regulation 9(1).

The enforcement action we took:

Cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not support the independence of the service users. Regulation 10(2)(b).

The enforcement action we took:

Cancellation of the providers registration.

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 act in accordance with the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1).

The enforcement action we took:

Cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not effectively assess the risks to the health and safety of the service users, and did not do all that was reasonably practicable to mitigate any such risks.

Regulation 12(2)(a) and 12(2)(b).

The enforcement action we took:

Cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not take action when they were alerted to the risk of abuse. Regulation 13(3).

The enforcement action we took:

Cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes in place to assess, monitor and improve the quality and safety of the service (including the quality of the experience of service users in receiving the service); the provider did not assess, monitor and mitigate risks relating to the health, safety and welfare of the service users; Regulation 17(2)(a) and 17(2)(b).

The enforcement action we took:

Cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider did not take the required actions when things went wrong within the service. Regulation 20.

The enforcement action we took:

Cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not display their rating on their web site. Regulation 20A(2).

The enforcement action we took:

Cancellation of the providers registration.