SHC Rapkyns Group Limited

# The Laurels

## Inspection report

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## Ratings

| Overall rating for this service | Inspected but not rated |
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|---|---|
| Is the service safe? | **Inspected but not rated** |
| Is the service well-led? | **Inspected but not rated** |

# Summary of findings

## Overall summary

About the service

The Laurels is a residential care service that provides nursing and personal care for 9 people and younger adults with learning disabilities or autism spectrum disorder and physical disabilities at the time of the inspection. The service can support up to 41 people.

The service is larger than current best practice guidance and consisted of four separate Lodges within one building. At the time of then inspection, all nine people were living in one lodge. The service was in private grounds in the countryside. The service is bigger than most domestic style properties. There were identifying signs on the road before the service's private drive, the service grounds and on the exterior of the service to indicate it was a care home. Staff wore uniforms and name badges to say they were care staff when coming and going with people.

The Laurels is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation in relation to incidents that occurred between 2016 and 2018. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found

There was unsafe assessment, monitoring and management of risk for people with support needs regarding epilepsy, constipation, behaviours that may challenge, nutrition and hydration, choking and aspiration. Risks associated with people's deteriorating health were not always assessed or monitored safely. This exposed people to risk of harm.

Medicines were not always managed safely. People had not always received their medicines as intended when required. Staff did not always have the required competencies or knowledge to meet people's individual needs safely.

Staff practice and reporting systems to safeguard people from abuse were not always effective. Lessons were not always learnt, and actions were not consistently taken to investigate safety incidents and prevent them re-occurring.

People's care records were not always up to date or accurate. Service management and the provider's wider quality assurance and governance systems had not always ensured actions were taken to address any issues and risks in a timely manner. The provider had failed to act upon known areas of concern, non-compliance and risk, to improve the quality of care for people at The Laurels.

Rating at last inspection

The last rating for this service was Inadequate and there were multiple breaches of regulations. We published a report of our findings on 8 November 2019.

At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected

We undertook this targeted inspection to check on specific concerns we had about management of risks for people with epilepsy, constipation, behaviours that may challenge, complex eating and drinking risks, choking and aspiration, and skin integrity support needs. We also had concerns about unsafe management and use of medicines, the provider's governance framework, quality assurance systems and how they were working in partnership with other agencies. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

Enforcement

We have identified two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations 12 and 17 in relation to: safe care and treatment and good governance. We also identified a new breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulation 13 in relation to safeguarding people from abuse.

On 26 May 2020 we imposed conditions on the provider's registration telling them how they must act to address serious concerns regarding unsafe care for people with known risks associated with their support needs regarding epilepsy, constipation, behaviours that may challenge, nutrition and hydration, choking and aspiration and monitoring and acting in response to people's deteriorating health. The condition requires the provider to submit a monthly report to the Commission on their actions to improve in these areas.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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| **Is the service safe?**<br>The Service was not safe.<br>Details are in our safe findings below. | **Inspected but not rated** |
| **Is the service well-led?**<br>The Service was not Well-Led.<br>Details are in our well-led findings below. | **Inspected but not rated** |

# The Laurels

**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 under the Care Act 2014.

This was a targeted inspection on a specific concern we had about management of risks for people with epilepsy, constipation, behaviours that may challenge, complex eating and drinking risks, choking and aspiration and skin integrity support needs. We also had concerns about unsafe management and use of medicines.

Inspection team

This inspection took place over four days between 19 and 22 May 2020. The inspection team consisted of two inspectors, a pharmacy specialist and a regional medicines manager.

On 19 May two inspectors carried out an inspection visit to the service. The pharmacist specialist and medicines manager reviewed medicine records off site and spoke with staff remotely.

Between 20-22 May 2020, all four members of the inspection team reviewed care and medicine records and spoke with staff remotely.

Service and service type

The Laurels is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

At the time of the inspection, the service did not have a manager registered with the Care Quality Commission at the time of the inspection. This meant the provider held the sole legal responsibility for how

the service is run and for the quality and safety of the care provided.

Since the inspection, the service now has a manager registered with the Care Quality Commission. 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.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because we needed to work with the provider to agree the safest way to inspect during the Covid-19 pandemic to minimise the risks to people who live at the service, staff and our inspection team.

What we did before the inspection

Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us since the last inspection by the provider as well as the local authority, other agencies and health and social care professionals.

We advised the provider about the purpose of the inspection and the areas of concern we had. We asked them to share information relating to these specific concerns so we could review this before, during and after the site visit to minimise the time we spent in the service. We worked with the provider to plan the safest way to inspect the service during our site visit.

During the inspection

We spoke with both service managers, a registered nurse and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed people's care and medicine records. We observed people being supported during lunch. We visited some people's bedrooms and medicine storage areas to inspect equipment.

After the inspection

We continued our review of people's care and medicine records. We spoke with two healthcare assistants, a registered nurse and the service managers via telephone. We reviewed training records, rotas, incident reports and quality assurance records.

Inspected but not rated

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about risk management and medicines. We will assess all the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management, staffing

●Risks for people with complex eating and drinking and nutritional needs were not always monitored or managed safely. One person was known to refuse food and drink for extended periods. The person was prescribed nutritional supplements to be given three times daily and one extra PRN daily if not eating. The person had a 'Nutrition Protocol' risk assessment that advised staff of the actions they should take should the person refuse food or drink.

●These actions included offering an alternative meal or drink and then food and fluids every hour thereafter and asking other staff to try supporting them. If the person had not eaten or drank for 12 hours the GP should be contacted and their vital signs monitored and documented. After 24 hours, support from the person's family should be sought to help encourage them to eat.

●We reviewed the person's daily notes for May 2020 which showed that they had eaten only one small chocolate bar between the afternoon of 5 May and the afternoon of 12 May. The person's Medicine administration records (MAR) showed they had refused half of their prescribed nutritional supplements during this period. During this period the person's fluid intake varied, and on some days they drank as little as 400ml.

●There was no record in the person's daily notes or on their MAR charts to evidence staff had taken any of the actions in their nutrition protocol when the person had not eaten or drunk enough. We asked the manager about this and they told us they were aware of the issues with the person refusing to eat. They confirmed the protocol was available for staff to access and could not explain why staff had not acted to follow the guidelines within it. This placed the person at serious risk of malnutrition.

● Risks to people with epilepsy were not always being monitored, assessed or managed safely, exposing them to high risk of harm. For two people living with epilepsy, we found inconsistent and conflicting information in their epilepsy care plans, risk assessments, and protocols for administering medicines while they were experiencing a seizure. This increased their risk of receiving inconsistent or incorrect support that may not meet their needs safely.

●For example, we found one person had not been given emergency rescue medicines after experiencing a

seizure within the timeframe stated in their protocol. We were told by one of the managers and a registered nurse this was because the protocol was not correct. However, the protocol had not been amended and there was no other guidance to direct staff and make sure they were aware of the right action to take. This placed the person at risk of not receiving safe care and being at high risk of harm in the event of experiencing a prolonged seizure.

● People were not always supported to monitor or manage risk associated with their constipation needs. There were inconsistencies in guidance and information to help staff understand how to support people to safely manage their constipation needs. This increased the risk that staff may not know how to support people to keep safe if they became constipated.

●For example, one person's medicines care plan advised to administer 'as and when required' (PRN) laxatives to alleviate their constipation after two days of not opening their bowels. We checked and could find no guidance about how and when to administer these. We asked the manager and they confirmed the person had not been prescribed these medicines. Three other people also had inconsistent or missing information about how support them with their PRN laxatives or when to seek further medical advice if they became constipated.

●Where actions had been identified to help keep people safe if they became constipated, we found these were not always taken by staff. One person's constipation risk assessment advised if the person had no bowel movement for three days to contact the GP. There had been a seven-day period in April 2020 where the person had not had a bowel movement. Staff had not contacted the GP until the fifth day of not having their bowels opened. Another person in April 2020 had not been offered their PRN enema when required during a period of extended constipation. This placed both people at risk of harm.

● Risks relating to people's behaviours that may challenge were not always assessed, monitored or managed safely. We found four people with recognised behaviours that may challenge had not been supported to adequately assess the functions behind their challenging behaviours. These people had various behaviour support plans in place. However, these did not always contain adequate guidance about how to support them to prevent their behaviours that may challenge from occurring or escalating. This increased the risk of harm to people and staff.

● Risks of aspiration (breathing in liquids, food or saliva) and choking for people were not always assessed, monitored or managed safely. Some people living at the service had been diagnosed with reflux. Staff had not supported people with a diagnosis of reflux to identify the potential risk of aspiration this posed and assess what actions were needed to help prevent this happening. This placed these people at high risk of potential harm. Concerns had been raised by a visiting health and social care professional on 13 May 2020 that one person had been supported to lie flat in bed for many years, which increased the risk of the person aspirating and could have contributed to their frequent hospital admissions for aspiration pneumonia.

●One person's risk assessment stated their speech and language therapists' eating and drinking guidelines recommending safe ways to eat and drink should always be available to ensure staff knew how to support them to reduce the risk of aspiration and choking. There had been an incident in January 2020 where their guidelines had not been available for staff to reference for an eight-day period following their discharge from hospital without the guidelines. The absence of guidelines providing clear directions about people's support needs increased the risk that staff may not know how to support them safely. This risk was increased due to the high use of agency staff who may not know people regularly working at the service.

● Nurses and support staff monitored people's well-being daily by talking with people and observing their physical and emotional presentation. Nurses used a standardised system for recording and assessing baseline observations of people's health indicators called National Early Warning Score (NEWS). NEWS was designed to ensure people could be supported to receive or access healthcare support and services quickly.

● We found examples when staff had not acted when people's NEWS scores indicated this was necessary to repeat observations and escalate concerns. We saw one person's NEWS scores had not been scored correctly. This placed the person at risk of harm and of not receiving the treatment they needed in a timely manner.

● The service deployed agency registered nurses (RGNs) and healthcare assistants (HCA) alongside permanent staff. Not all agency RGNs had received or had completed clinical competency assessments or further training and support. Both agency and permanent staff had not always been trained in subjects relevant to people living at the service, such as health monitoring tools and behaviours that may challenge. This increased the risk that there may not be enough skilled and knowledgeable staff to be able to meet people's needs safely.

● For example, we found one person had been physically and verbally challenging towards specific agency staff members. It was identified that when staff had been supporting this person, the person didn't like being 'talked down to' and made to 'feel little' which had triggered their behaviours that may challenge. We found recent instances where agency RGNs had not recorded or administered medicines correctly and recorded NEWS scores or acted appropriately to escalate concerns or repeat observations. This placed people at risk of harm and of not having their needs safely and effectively met.

Using medicines safely

●Following issues with medicines found at an inspection in June 2018, we imposed a condition on the provider's registration to ask that an independent pharmacist complete monthly audits at the service. The purpose of this condition was to support the service to check that specific areas of practice including ordering, storing, disposing and administration of medicines were being carried out safely and to support staff to address any issues.

● Prior to this inspection we had sought assurances from the provider on several occasions in relation to intelligence they and partnership agencies had shared with us regarding unsafe medicine practice. At this inspection we checked and found medicines continued to be unsafely managed. Despite frequent weekly and monthly external and internal audits of medicine systems and practices at the service, these audits have either not identified issues or had not led to issues being resolved.

● Medicines were not always managed safely, exposing people to risk of harm. Some people's 'as and when required' (PRN) protocols for their epilepsy, constipation pain relief and skin condition medicines and topical creams were missing, out of date, lacked detail or contained inconsistent information. This increased the risk staff may not know how much medicine people needed and when to administer this. There had been recent incidents where people had not received their PRN constipation medicines when necessary.

● People had Medication Administration Records (MAR). Some people's MAR contained inconsistent information about the medicines they needed, how their medicines should be taken or used, and how often. Staff had not always completed a MAR to document why they had administered PRN medicines for people.

Two people's MAR did not specify the correct route of administration for their medicines. This increased the risk people may not receive their medicines safely or as intended. We found recent incidents where people's MAR showed they had not received the correct amount of their medicines, according to their prescribing instructions or PRN protocols.

●Staff had not always been trained and assessed as competent to undertake medicines tasks before administrating medicines for people. Some people required medicines to be given via PEG tube. A PEG (percutaneous endoscopic gastrostomy) is a tube that is inserted into a person's abdomen, so they can receive liquid food, fluids and/or medicines directly to their stomach.

●A care worker who had not received medicines competency assessment for PEG administration carried out a medication round on the 12th April 2020 that included giving people medicines via their PEG. We were told that this happened because the nurse that was due on shift had not turned up. This placed the person at risk of not receiving their medicines safely or effectively.

● Some medicines required storing in a fridge within a certain temperature range to ensure they remained effective. Whilst staff stored medicines in a fridge and recorded the temperature of the fridge, they had not identified minimum and maximum fridge temperatures. This increased the risk staff may not recognise when the fridge had become too hot or cold to effectively store people's medicines.

Learning lessons when things go wrong

● Systems in place for staff and management to report, review, and investigate safety incidents and act to prevent them re-occurring were not always effective. This increased the risk that incidents would not be investigated and acted on to prevent them from happening again.

●During this inspection, we identified issues relating to safety incidents that had either not been reported or had not been acted on in relation to medicine management, people's epilepsy, constipation, complex eating and drinking, and behaviours that may challenge support needs.

●For example, for one person we highlighted inconsistencies and conflicting information in their epilepsy PRN protocols and care plans, and the high risk this posed the person, during our previous inspection in August 2019. However, we found the exact same issues remained at this inspection, meaning the person had been placed at an avoidable high level of risk for nine months with no action taken by the provider.

●During the August 2019 inspection we raised concerns about staff not managing the risk of people refusing to eat and drink. We also raised concerns about the lack of PBS plans and functional assessments for some people living at The Laurels. We received information from the provider telling us that action had been taken to improve people's behaviour support, including making referrals to external professionals to manage nutrition risks and help staff carry out functional assessments, write PBS plans and deliver safer and more effective care. However, we found these actions had not been taken and the same people remained at risk.

●We received information from external health and social care professionals showing they had highlighted to the provider the risk of aspiration for people with reflux, and concerns there was a lack of adequate assessment and actions to manage this risk in February 2020. However, no action had been taken and the same professionals found the issues remained when they visited in May 2020.

●The themes of risks and concerns found at this inspection relating to epilepsy, choking and aspiration,

behaviours that may challenge, constipation, and monitoring people's healthcare needs have been highlighted in inspection reports about many of the provider's other services. This information had not led the provider acting to prevent similar risks to people at The Laurels being reduced.

The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to people, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of people. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following the inspection, due to our serious concerns regarding the continued breach of regulation 12 and continued unsafe practice in specific areas of care delivery we imposed two additional conditions on the provider's registration regarding The Laurels on 26 May 2020.

●Each month the provider must designate a competent individual to undertake an audit of all care plans and assessments for service users at The Laurels detailing how service users' needs and any risks associated with these needs have been assessed and planned in relation to the management of epilepsy/seizure treatment, constipation, choking and aspiration, nutrition and hydration and service users' deteriorating health. The report must include actions identified by the registered provider to monitor and manage risk in these areas of practice and say when these will be completed by.

●The provider must appoint an independent qualified positive behaviour specialist to assess of all behavioural needs of service users at the Laurels and a review of how this is managed at that location. This must be thereafter be completed by the specialist bi-annually. The provider must submit a monthly report detailing concerns and actions identified from the review and say how and when these are being managed on an on-going basis.

● During the inspection we observed a lunch time service and did not see any person being placed at risk of harm. The manager told us following the safeguarding in January 2020, they had since provided the eating and drinking guidelines that had been unavailable for one person for staff to access as required.

Systems and processes to safeguard people from the risk of abuse

● Systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective. Since the last inspection in August 2019 there had been safeguarding concerns raised concerning people using the service by partnership agencies after visiting the service.

●The concerns included allegations of neglect against people using the service by staff with regards to their constipation, nutrition and aspiration support needs. The provider was not always aware of these allegations until brought to their attention by external professionals. The provider had not always reported or acted on the allegations when they had been aware of them, to ensure people were protected and improve systems to keep people as safe as possible.

●People had been placed at risk of harm due to staff not providing their medicines, constipation, epilepsy, eating and drinking, and behaviour support safely. There were concerns that appropriate healthcare monitoring had not taken place to ensure that further medical intervention was taken if necessary.

The provider failed to ensure systems and processes protected people from abuse and improper treatment.

This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We spoke with both the service managers throughout this inspection to raise our concerns regarding incidents and safeguarding concerns that had not been reported or acted on. They offered assurances they would act to help review, report and implement necessary changes in relation to all previously unidentified and outstanding safeguarding concerns. Following the inspection, we received confirmation via notifications and information from the provider and partnership agencies these processes had begun.

Inspected but not rated

# 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 the last inspection this key question was rated as Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check specific concerns we had about the providers governance framework, quality assurance systems and how they were working in partnership with other agencies. We will assess all the key questions at the next comprehensive inspection of the service.

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

● At the last inspection in August 2019, we had found that the provider was in breach of five Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, was rated Inadequate and remained in Special measures.

●At this inspection we found that people remained at risk of receiving unsafe, poor quality or inadequate support. From the targeted areas of concern that we looked at, we found a repeat breach of regulations 12 and 17 in relation to safe care and treatment and good governance. We have also identified a new breach of Regulation 13 in relation to safeguarding people from abuse.

●The risks and concerns found at this targeted inspection have been highlighted in inspection reports about many of the provider's other services. This information had not led to similar risks to people at The Laurels being reduced.

●The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at The Laurels. We had received written assurances following the August 2019 inspection that the provider would be acting to address serious concerns regarding people's medicines. We had been shared information from the provider in relation to their appeal against the Notice of Decision to vary a condition of the provider's registration and remove this location, about how they were acting to address epilepsy, constipation and behaviours that may challenge risks. These assurances had not been substantive and at this inspection we had found these concerns remained.

●Systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively. Since the last inspection in August 2019, the provider had deployed two on-site managers, a clinical lead role and a deputy manager. There had been consistent additional support and oversight from the organisations 'Quality Team', Behaviour and Autism lead, nominated individual and senior management team. Internal audits had been occurring consistently and actions from these audits were added to centrally accessible electronic improvement plan (SIP), along with a timeframe for when they

should be addressed by. However, the deployment of additional managerial and quality support staff and internal audit and quality assurance checks had not ensured risks and issues were always identified, monitored and acted on in a timely manner.

●We reviewed the SIP and saw high and medium risk issues, and their associated actions, were incomplete and had significantly overrun their timeframes for safe completion. This included actions in relation to PRN protocols, behaviours that may challenge, epilepsy, clinical oversight, clinical competence of staff including NEWS and maintaining accurate care plans and records. We saw actions relating to constipation risk management, medicine fridge temperature storage, and updating care plans marked as complete as of January 2019, but we had found during this inspection that in fact these actions were unresolved and issues in these areas remained outstanding.

●During this inspection, we found the provider had not assessed, monitored and reduced risks relating to the health and safety of people. Failure to manage constipation and nutrition risks had resulted in people not receiving PRN medicines and supplements and not receiving their assessed care and support to make sure they were as safe as possible. Failure to manage on-going epilepsy, medicines, healthcare monitoring, aspiration and choking and behaviours that may challenge risks had exposed people to a consistently high risk of harm.

●Since the last inspection in August 2019, external audits from the local authority and clinical commissioning group (CCG) had taken place which had identified quality and safety issues that the provider had not always been aware of and had not been taking appropriate steps to manage before alerts had been raised externally.

● The provider had not ensured that an accurate and contemporaneous record in respect of each person using the service was in place. During this inspection the provider was in the process of transferring all their care plans and records to an electronic system. This process was not yet finished, and staff were using both the electronic system and paper records until the change had been completed. For both electronic and paper formats, we found people's care plans and risk assessments regarding medicines, aspiration and choking, epilepsy, behaviours that may challenge and constipation risks were not always accurate, complete or up to date.

●The provider had not ensured that staff at all levels understood their responsibilities, regulatory requirements, met conditions of their registration and managed staff accountability effectively. Staff had not always met people's support needs or reported and acted in response to quality and safety issues. Staff continued to not always have the right, skills, knowledge or experience to manage risks and deliver safe care.

●The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. This was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Working in partnership with others

● The local authority and CCG provided feedback there had been a recent improvement in the provider's willingness to engage with their teams to help address safeguarding issues and when working together during assessments and reviews of people's care.

●The manager and nominated individual told us they had been promoting partnership working within the staff team and wider organisation by explaining the benefits of this for people who used the service. The manager told us they felt this was helping them and staff to actively make referrals, share information more openly and build positive relationships with other agencies.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to people, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of people. |

**The enforcement action we took:**

We imposed conditions on the provider's registration telling them how they must act to address serious concerns regarding unsafe care for people with known risks associated with their support needs regarding epilepsy, constipation, behaviours that may challenge, nutrition and hydration, choking and aspiration and monitoring and acting in response to people's deteriorating health. The provider must submit a monthly report to the Commission on their actions to improve in these areas.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider failed to ensure systems and processes protected people from abuse and improper treatment. |

**The enforcement action we took:**

We imposed conditions on the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. |

**The enforcement action we took:**

We imposed conditions on the provider's registration.