

Stephen Oldale and Susan Leigh

Eboracum House

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 well-led?	Inadequate ●

Summary of findings

Overall summary

About the service

Eboracum House is a residential care home providing personal care to up to 18 people. There were 14 people living at the home at the time of our inspection.

Accommodation is provided over two floors in a detached period building with a large garden.

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

Systems were not robust to safeguard people from abuse. Not all risks had been appropriately assessed. Individual plans to support people to evacuate safely in the event of a fire were not readily available. Staff told us, and we observed, staffing levels were not sufficient to support people safely. There was no management oversight of how staff were deployed. Medicines were not administered safely. Staff were wearing PPE appropriately, however cleaning was not well-managed or appropriate to support robust infection prevention and control processes.

Care plans were detailed and had been reviewed regularly, however there was some inconsistency in the information recorded; some information was out of date. Training was not up-to-date and there were inconsistencies in the records kept. People were supported to eat and drink however where people were at risk of malnutrition or dehydration there were inconsistencies about how this was managed. A handbook used to record information about people was not reviewed. Staff recorded when they had contacted health professionals however there were inconsistencies about how this was recorded and how health concerns were followed-up. People's rooms were personalised and were homely, however personal information about people was recorded in a visible place outside their room, which did not promote confidentiality, privacy and dignity. There were inconsistencies about whether people had capacity to consent to their care and support, and consent was not consistently recorded. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Governance arrangements were not robust and checks and audits had not identified the issues we found. Manager oversight was not evident. Not all checks and audits were documented. The home manager had not submitted statutory notifications as required. There was no overarching plan to track improvement actions.

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

Rating at last inspection

The last rating for this service was Good (published 28 February 2019).

Why we inspected

We received concerns in relation to management of the home, low staffing levels, lack of choice, and poor

access to health professionals. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the Safe, Effective 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.

Since our inspection visit the provider confirmed they had re-organised folders for DOLS, statutory notifications and safeguarding. The provider has told us they have provided some staff with the opportunity to undertake a senior role and have highlighted on staff rotas to clarify who is responsible for leading each shift. They have also amended handover arrangements so there is manager oversight. This means tasks to support people safely will be managed and overseen. The provider has also organised training in continence care, care planning and record keeping, which will be completed by the end of December 2020. The provider has revised cleaning schedules and put in place checks to ensure cleaning is completed.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Eboracum House 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to consent, safe care and treatment, safeguarding, good governance, making sure appropriate staff were employed, and making sure there were enough staff to support people safely at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures

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 well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Eboracum House

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 Care Act 2014.

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

Two inspectors visited the home, and one inspector spoke to staff over the telephone. An Expert by Experience spoke to relatives over the telephone. 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

Eboracum House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have 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. The previous registered manager had transferred location. A new manager had been appointed who had been at the home since July 2020. At the time of the inspection they had not made an application to register.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with two people who used the service and three relatives about their experience of the care provided. We spoke with seven members of staff including the provider, the operations manager, the manager, the deputy manager, care staff and a cook.

We reviewed a range of records. This included three people's care records and various medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

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

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 good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not always properly assessed or managed safely. For example, personal emergency evacuation plans (PEEPs) were not available in the event of an emergency. The provider confirmed after the inspection this had been remedied. A fire exit door was open and the alarm was turned off, which meant staff would not be alerted if people left the home. The provider explained remedial work to this issue had been delayed. We asked the provider to ensure the alarm was turned on at all times, which they confirmed during the inspection.
- Care plans contained contradictory information which meant that not all risks had been identified or assessed.
- Risk assessments that were in place had been regularly reviewed.
- The home undertook regular servicing and maintenance checks on the building and equipment.

People were at risk because risk had not always been identified and actions had not always been taken to mitigate those risks. This is a breach of Regulation 12(1)(2)(a)(b), Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not administered safely. Controlled drugs (CDs) were not stored as they should be and did not have appropriate corresponding records. Medicine stocks did not tally with medicine administration records (MARs), which meant medicines could not always be accounted for. Appropriate disposal of medicines had not taken place.
- One staff member told us they had not had any medicines training since before our last inspection visit (over a year ago). The training matrix showed eleven staff out of seventeen had received training on medicines administration, however inconsistencies in staffing rotas meant we could not always be assured a trained staff member was available to administer medicines.
- A medicines competency list showed only three staff had a medicines competency check completed; however one of these staff members had not completed medicines training. There were no other records of medicines competency checks, despite staff undertaking medicine administration.

People were at risk because proper and safe management of medicines was not in place. This is a breach of Regulation 12(1)(2)(g), Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- Cleaning was not robust and had not been co-ordinated or managed. Some hand gel dispensers were empty. We discussed this with the provider and the manager who told us one cleaner was not at work but had told staff to undertake sanitising of touch surfaces. They agreed to ensure dispensers were checked and re-stocked regularly.
- We were not assured cleaning was completed appropriately. A staff member, who was not a domestic, told us, "I do the cleaning when I am here, but it's not really getting cleaned." There was no evidence to confirm touch surfaces were being sanitised and we did not see this taking place during our inspection visit.

People were at risk because robust cleaning was not taking place. This is a breach of Regulation 12(1)(2)(h), Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was preventing visitors from catching and spreading infections. We were assured that the provider was meeting shielding and social distancing rules. We were assured that the provider was admitting people safely to the service. We were assured that the provider was using PPE effectively and safely. We were assured that the provider was accessing testing for people using the service and staff. We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from neglect. The reporting systems did not ensure prompt action took place. A staff member said, "With what's gone off I don't think people are safe," and referred to recent incidents which had occurred recently.
- Recording of safeguarding incidents was inconsistent. Procedures for reporting safeguarding concerns had not been followed. The local authority had not been informed of all safeguarding concerns.
- Staff were not up to date with safeguarding training. Training records showed eight staff had completed safeguarding training; this was less than 50%.

People were at risk because systems and processes did not prevent abuse and investigations were not undertaken appropriately. This is a breach of Regulation 13(2)(3), Safeguarding, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had been kept in their rooms without necessary reason during the Covid-19 pandemic. Relatives had raised concerns about this. Daily records showed people were self-isolating, despite them not having a reason to do so. Staff confirmed people had been self-isolating in their rooms. A staff member said, "It was when they (people) were isolating, they were all in their rooms." We discussed this with the provider, who said there had been a mis-communication with staff, however provider and manager checks did not prevent this happening. When the provider was notified they took immediate action.

People's liberty of movement had been restricted without reason. This is a breach of Regulation 13(4), Safeguarding, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and their relatives told us they felt safe. Relatives comments included: "The main thing is that [person] is happy and safe", "We are happy with everything", and "We have nothing but praise for the home and the staff".

Staffing and recruitment

- People were not supported by sufficient numbers of staff.

- A staff member told us, "There's not enough staff." Another staff member told us, "(It) gets a bit chaotic."
- Two people living at the home require two staff members to support them, however staff told us there was only two staff working on each shift and one of these staff members was required to administer medicines for over an hour each morning. Staffing rotas provided confirmed on most days two staff worked each shift. Staffing rotas also showed on some days only one staff member had worked. During our inspection visit three care staff were on shift.
- There were no senior care staff at the home despite reference made to them in the provider policies regarding medicines administration and training, for example. This meant staff were not deployed appropriately and tasks were not co-ordinated. A staff member told us "We decide between us." This meant there was a risk not all the tasks would get completed and the manager did not have any checks in place to ensure these were completed. After the inspection the provider told us changes had been made to how staff were deployed and senior opportunities had been given to some staff.

People were at risk because sufficient number of staff were not deployed. This was a breach of Regulation 18(1), Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were not recruited safely as thorough checks had not always been completed before employment commenced. References had been obtained after employment started and gaps in employment history had not been checked.

People were not protected from the employment of unsuitable staff. This was a breach of Regulation 19 (1), Fit and proper persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Accidents and incidents were recorded, however follow-up actions were not always fully recorded or completed.
- Robust consideration of trends and themes was not evident.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

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

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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- DoLS information was not co-ordinated or effectively managed.
- Capacity assessments were not always in place and proper consent processes had not always been followed. For example, one person who had been assessed as not having capacity had signed a consent form. Another person who had been assessed as having capacity had consent forms signed by a relative who did not have the authority to make this decision.
- Best interest decisions were not evident to demonstrate correct processes in line with the MCA had been followed. A MCA assessment had been signed by a staff member, who the training matrix showed had not completed MCA training

Regulations relating to the MCA were not followed consistently. This was a breach of Regulation 11(1), Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- There was no system in place to ensure the cook was informed about people's dietary needs and choices. The cook told us they asked people about their needs because "the staff don't have time". A sign on the wall told people to 'speak to staff about the ingredients in your meal when making your order'. This was a risk because not everyone living at the home had capacity to provide accurate information to ensure their dietary needs were met safely, which meant they may be given food unsuitable or unsafe for their needs.

The above was a breach of Regulation 12(1)(2)(a)(b), Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's food likes and dislikes were documented in their care plans.
- People were given a choice of food to eat and alternatives were available if people did not like the choice offered.
- People were supported to eat and drink. We observed staff frequently offered food and drink to people and encouraged and reminded people to eat and drink. A person commented, "Very satisfied," when asked if they had enjoyed their breakfast.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People were not always supported in a way which promoted their health and physical well-being. Inconsistencies in care plans and daily records meant it wasn't clear who had responsibility for accessing health professionals and in some instances delays in accessing health professional advice were evident.
- Handovers were not co-ordinated and the manager had no oversight of these.

People were at risk of not receiving health care when needed. This is a breach of Regulation 17(2)(b), Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People were not always supported by appropriately trained staff. Not all staff had received training or refresher training. The provider's training policy stated all staff should receive yearly training and competency checks in the areas the provider deemed mandatory and this had not taken place.
- The training matrix, competency lists and staff supervision and appraisal trackers did not contain the same list of staff. For example, one staff member was recorded on the appraisal tracker but not on the training matrix.
- Some staff had received a competency check but had not undergone training prior to this.

This was a breach of Regulation 18(2), Staffing, 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

- People's needs were assessed in line with current standards and guidance so the home was clear about whether they were able to meet people's needs safely and effectively.
- A pre-admission assessment was completed which documented people's needs and preferences.
- Detailed care plans were produced from the pre-assessment. Records showed care plans had a monthly evaluation, however there were inconsistencies between care plans for individuals.
- There was not always evidence people, or their relatives where appropriate, had been involved in care planning or care plan reviews.

Adapting service, design, decoration to meet people's needs

- The home had arranged for frames next to the door of each person's room, which were to contain a personalised photograph or picture, however these had been used by staff to record night-time observations for the people living at the home. We discussed this with the provider who arranged for night-time observations to be kept elsewhere.
- People's rooms were decorated with personal items, such as photographs and ornaments. However, one person who had moved rooms still had some of their personal items left in their old room.
- The home had been adapted to meet the needs of people living there. For example, dementia friendly signage was evident. An environment action plan showed planned further adaptations and improvements in the home. We discussed with the provider, ensuring people's involvement with this.

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 good. At this inspection this key question has now deteriorated 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

- The provider's systems and processes to monitor and oversee the quality of care people received was not effective. The provider told us they undertook fortnightly visits and performed audits of care plans, however there was no record of these. The operations manager undertook weekly spot checks and monthly quality assurance visits, however these had not identified the issues found during our inspection visit.
- Audits in place for medicines were ineffective as they had not identified any of the issues found during this inspection.
- We were not assured of any manager oversight. There was no evidence the manager undertook any checks and audits. The manager told us they undertook a daily walk-round of the home however there was no evidence to support this. When asked whether the manager wrote down anything about these checks they said, "Sometimes". We were not provided of any written evidence of the checks the manager told us they undertook.
- Staff wrote information about people in a daily 'handbook' however there was no evidence the manager had oversight of this. For example, the manager was not aware a person had died in hospital three weeks prior to the inspection visit. We asked the manager how they ensured staff completed a handover and they told us, "One staff member says right I'm going to do a handover". We were not assured the manager had oversight of this.
- A staff member told us, "There's no one making sure people (staff) do what they need to do", and, "I don't want to come to work".

The above is a breach of Regulation 17(1)(2), Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post and when we inspected the manager had not submitted an application to register with the CQC.

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 provider had not ensured their legal responsibility to be open and honest when something goes wrong had been fulfilled. For example, two recent incidents required safeguarding alerts to be raised, and the

manager had not done so.

- A staff member told us they felt people weren't safe sometimes because some staff did not fulfil their duties and managers had not taken not take action about this.

Continuous learning and improving care

- There was no evidence available to show how the service continually learned and improved care.
- The service had deteriorated since our last inspection visit. A staff member told us, "We worked so hard in the past to get things better...and now I feel we have gone back down."
- Staff told us how they felt able to be involved in staff meetings which took place monthly, however another staff member said, "Communication is a big thing, staff need to listen", and gave an example about medicines being continually stored incorrectly without action being taken.

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

- Care plans contained a good level of detail and were person-centred, however daily records did not evidence how good outcomes had been achieved.
- A staff member told us the manager was open and approachable, however another staff member told us they did not think the manager listened.
- One person's care plan said they enjoyed listening to country music and during our inspection this person was sat in a quiet area of the dining room listening to the type of music they preferred.
- People were undertaking a range of activities according to their preference.

Working in partnership with others

- The home had worked with Public Health England during the Covid-19 pandemic, however advice given had not always been followed. For example, people had self-isolated in their rooms when the home had not been advised to do this.
- The home had links with local GP practices, Community Matrons, pharmacies and had worked in conjunction with Infection Prevention and Control nurses.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People had their protected characteristics documented in their care plans and staff were aware of these.
- Monthly quality assurance visits documented the involvement of people.
- Relatives told us they were kept informed about their loved one's however this was not always documented.
- The home had recently sent questionnaires to people and relatives. Overall feedback was positive, however analysis had not yet taken place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Regulation 11(1), Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulations relating to the MCA were not followed consistently.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Regulation 13(2)(3), Safeguarding, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because systems and processes did not prevent abuse and investigations were not undertaken appropriately.</p> <p>Regulation 13(4), Safeguarding, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's liberty of movement had been restricted without reason.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Regulation 19 (1), Fit and proper persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the employment of unsuitable staff.</p>

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

Regulation 18(1), Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because sufficient numbers of staff were not deployed.

Regulation 18(2), Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because staff had not always received appropriate training to support people safely.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12(1)(2)(a)(b), Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because risk had not always been identified and actions had not always been taken to mitigate those risks. People were at risk of not receiving health care when needed.</p> <p>Regulation 12(1)(2)(g), Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because proper and safe management of medicines was not in place.</p> <p>Regulation 12(1)(2)(h), Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because robust cleaning was not taking place.</p>

The enforcement action we took:

We have issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17(1)(2), Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Provider oversight was not robust. Manager oversight was not evident.</p> <p>Regulation 17(2)(b), Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of not receiving health care when needed.</p>

The enforcement action we took:

We have issued a Warning Notice