Delves Court Care Home Ltd

Delves Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Delves Court Care Home is a nursing home providing personal and nursing care to up to 64 people, including people with dementia. At the time of our inspection there were 55 people using the service.

People's experience of using this service and what we found
People were not always protected from the risk of harm; systems were not effective in assessing, monitoring and mitigating risks to people's health, safety and welfare. People weren't always supported by registered nurses for their nursing care needs. There weren't always sufficient numbers of staff available to help people. This meant people were sometimes left at risk of harm or without timely care.

People didn't always receive the support they needed to manage weight loss, however people reported they were given meal choices and drinks as required. People were supported by trained staff but had varied experiences of staff skills and practice.

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.

People did not always receive support that was caring and maintained their dignity. Whilst many people found the staff caring and compassionate, a lack of staff sometimes led to shortfalls in people's experiences. People didn't always receive adequate support to maintain their independence.

People's person-centred needs weren't always at the forefront of their support. However, people were supported with a range of meaningful activities and staff were attentive to people's emotional and social needs.

Quality assurance systems were not always effective for people. This meant the action taken by the provider had not always ensured people received consistent, good quality and safe care. However, people and relatives spoke positively about the management of the service. Systems were in place to seek feedback and resolve people's complaints.

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

Rating at last inspection
This service was registered with us on 15 May 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about end of life care and the staffing and safety of the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement
We have identified breaches in relation to how people's safety was managed, the staffing of the home, how people's rights were promoted, people's person-centred needs and how the service was run at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The 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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Delves Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors, a pharmacist specialist and a nurse specialist advisor.

Service and service type
Delves Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Delves Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there were two registered managers in post, who managed the service together.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since registration. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke to 9 people and 8 relatives about their experience of the care provided. We spoke with 5 professionals who have contact with the service. We spoke with 12 members of staff including the registered managers, the unit manager, an activity coordinator, a housekeeper, a cook and 6 members of staff. We reviewed a range of records. This included 14 people's care plans, a range of medicine administration records (MAR) and 4 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems. We spent time observing the care that people received within the home.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● There was not an effective system for calculating the staffing required. A dependency tool we reviewed contained inaccuracies, and the registered managers advised that it contradicted a separate tool also used at the service. This meant the system used was unreliable in assessing the true staffing requirements of the home.

● People weren't always supported by a registered nurse for their specific nursing needs. There were occasions when registered nurses were not available at the home, at times when people required nursing treatment. This meant people's nursing interventions were completed by a senior carer, without a registered nurse to have clinical oversight of people's care.

● Tasks requiring nursing intervention weren't always delegated to care staff safely. We observed senior carers completing nursing tasks while being overseen by an agency nurse with no knowledge of their competency or training. This put people at risk of harm.

● At the time of our inspection there were no nurses employed by the provider at the home; the service was staffed by agency nurses. Whilst recruitment of nurses was underway, this put people at risk of a lack of continuity of care. For example, during our inspection the nurses and care staff were unable to tell us how many people required daily wound care. However, the provider has now recruited a clinical lead to start at the service in the near future.

● During our inspection we observed, and were told of occasions, where a lack of staff presence put people at risk of harm. Inspectors intervened in an incident between 2 people as there were no staff available to step in. People told us of occasions where they had to wait for personal care or staff support. One person told us that having to wait meant they experienced prolonged pain.

● People, staff and relatives consistently told us there weren't enough staff to meet people's needs throughout the home. One person said, "You press the buzzer and it takes quite a long time before it gets answered." Another person told us, "We need more carers. I think this has been expressed time and time again."

There was a failure to ensure sufficient numbers of suitably qualified staff were deployed to meet people's needs. This put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management; Using medicines safely

● People who had lost weight were not supported with robust actions. Whilst significant weight loss was referred to the GP, steps were not taken to support people while they awaited external input. Staff were unsure if any people were at risk of losing weight and the kitchen staff were not providing fortified diets to

those who needed them.
● People did not always receive nutritional supplements as prescribed. We found one person who was prescribed a number of daily supplements was only recorded as receiving them sporadically. We observed another person's supplement drink was left on their bedside table and no checks were conducted to review if it had been taken.
● People's medicines were not always received safely. For example, we found controlled drug patches were not always rotated in accordance with manufacturer advice. We also could not be assured that people were receiving creams as prescribed and medication records and body maps were not always completed.
● People had protocols in place for 'as and when required' (PRN) medicines. However, these were not readily available to staff as the paper records were waiting to be entered onto the online system. This put people at risk of inadequate or inappropriate use of these medicines.
● People did not always receive safe monitoring and management of wound care. We found 1 incident of an unexplained skin injury that hadn't been investigated to prevent reoccurrence. We also found one person's care records indicated they had been receiving incorrect treatment for a wound. Staff lacked knowledge about which people required support with regular dressing of wounds. This meant we could not be assured people were receiving the support they required to treat wounds.

We found no indication that people had been harmed. However, systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Preventing and controlling infection
● The provider had not followed protocols for responding to a COVID-19 outbreak. At the time of our inspection there were positive cases of COVID-19 at the home. We received feedback from stakeholders that the service had not reported this in a timely way and had admitted a person to the home prior to doing so. This put people at risk of harm through the spread of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The environment appeared clean and hygienic and regular cleaning was carried out throughout the building.
● People were supported appropriately to minimise the risk of spreading infection. People who had tested positive for COVID-19 were self-isolating and staff wore Personal Protective Equipment (PPE) in line with guidance.

Visiting in care homes
● Relatives told us they were supported to visit their loved ones as they wished. One relative told us they had been able to visit over lunchtimes to support and encourage their relative with their meal.

Learning lessons when things go wrong
● Systems were in place to review accidents and incidents and identify any learning. However, we found 2 incidents of unexplained bruising which were not fully investigated or documented. The provider took immediate steps to implement a more robust process.

Systems and processes to safeguard people from the risk of abuse
● People, staff and relatives told us people were safe at Delves Court Care Home. One family member said, "Yes, staff are careful and gentle with [my loved-one]. I can't fault the care."
● Systems were in place to identify, report and investigate any safeguarding risks to people. Incidents were recorded and referred to the Local Authority safeguarding team where appropriate. However, we found 1

instance where CQC were not notified of an allegation of abuse, in addition to the instances of unexplained bruising. The registered managers took steps to address this.

● Staff had received safeguarding training and understood the signs of abuse and how to report any concerns they may have.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty.

● People's capacity to consent to restrictions imposed by the provider wasn't always considered and documented. For example, 1 person had limited access to their cigarettes and occasional support to the outside area to smoke. The person's ability to consent to these limitations had not been explored.
● People's capacity and best interests weren't always considered in relation to religious or cultural choices. We found 1 person's cultural background and family beliefs regarding food were not at the heart of how the home supported them. The provider had not explored whether the person had capacity to make cultural and religious decisions, or if these decisions should be made in their best interests.
● Systems were in place to seek DoLS authorisations for people at risk of being deprived of their liberty. However, we found 1 person who was cared for in bed had been assessed by the service as lacking capacity to consent to their care and treatment. However, a DoLS authorisation had not been sought by the provider. The registered managers took immediate steps to address this.

The provider had failed to ensure people's rights were protected. This was a breach of Regulation 11 (Need for consent) 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
● Care plans and risk assessments were in place to detail people's specific needs and preferences. However, the quality of people's records varied and plans weren't always updated following changes to people's requirements. Some records we reviewed contained contradictory information. However, we found no examples of this impacting on the support people received. The registered managers had already identified

that this was an area for improvement and actions were underway to adopt an electronic system.
● People who experienced distressed or agitated behaviour had care plans to guide staff about how best to support them. Staff were knowledgeable about how to de-escalate difficult situations and support people who were in distress. Throughout the inspection we observed staff doing so in a calm and compassionate way.

Staff support: induction, training, skills and experience
● Staff did not receive specialist training relevant to the people they were supporting; for example, training in diabetes or Parkinson's disease. However, staff were generally knowledgeable about people's health needs and how to support them.
● We received mixed feedback from people about the skills and experience of the staff. Some people told us their experiences varied and there were some difficulties due to a language barrier with overseas staff. One person said, "It depends which one you get, some don't understand what you are saying. [Staff member's name] is lovely and will do anything for you." Another person told us, "They are very nice and try hard, but a lot can't speak the language. They come in and don't know what to do."
● Staff received an induction and training. Training was delivered through a mix of online courses and face to face sessions. Staff told us the training helped them in their roles and reported the provider was supportive in their professional development.

Supporting people to eat and drink enough to maintain a balanced diet
● Where people were at risk of losing weight, systems were not in place to ensure people received updated support in line with their changing needs. People who required support and encouragement with their nutritional intake didn't always consistently get the help they needed. For example, we found people who were prescribed supplements to increase their nutritional intake weren't always receiving them.
● People's experiences during meal times varied. We observed the lunchtime experience to be positive, with staff being attentive to people's needs. However, during breakfast time some people were left to wait and were unsure when they would receive something to eat.
● People who required specialist diets received these appropriately. The kitchen staff understood how to modify people's meals to manage their choking risks. We observed a staff member safely supporting a person to eat their meal.
● People told us that the food was enjoyable and they could get a drink as needed. People who didn't like the meal options available were offered alternatives. One relative told us, "[My family member] is eating properly. It's a big worry off my mind."

Adapting service, design, decoration to meet people's needs
● People's bedroom doors weren't personalised with individual names or pictures. This meant that people with dementia may have had difficulty in orientating to the surroundings. This also could lead to confusion for new or agency staff.
● Communal areas had clear signage in place to help people navigate throughout the home. For example, bathrooms and toilets had signs in place.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People and relatives said people were supported to access healthcare services as needed. We reviewed documents which reflected that professionals were consulted and referrals were made when appropriate.
● Professionals who regularly visited the home reported the staff team were responsive to advice and sought external support as needed. One professional informed us they had many examples of people's condition improving following admission to Delves Court Care Home.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People's independence wasn't always supported. Some people and relatives described how a lack of support and encouragement with required exercises had led to a decrease in the person's mobility. One person said, "I came to get better, but I'm not getting the exercise I need."
- We made conflicting observations and had mixed feedback about how people's dignity and privacy was promoted. While we saw many caring interactions, we also observed a staff member turning on a person's light to find something in their room, while the person was asleep. One person told us they weren't always treated in a respectful way. They said, "I was told they should knock, but they just walk in."
- Relatives told us their loved ones were well cared for. One relative told us how staff had gone above and beyond their role to support their family member when they were distressed. They told us, "The staff are lovely. A couple have given up their lunch breaks just to sit with [my relative]."
- Staff were compassionate and patient when supporting people who were displaying behaviour of agitation or distress. For example, we observed a staff member gently redirecting a person and engaging them in a discussion when they were becoming upset.
- Staff spoke positively about their roles and the people they supported. One staff member said, "I love my job. I love talking to the residents, listening to their stories and having that interaction."
- People were supported to celebrate important occasions. For example, the kitchen staff made a cake for each person on their birthday.

Supporting people to express their views and be involved in making decisions about their care

- Residents were invited to a monthly 'news and views' meeting where they could discuss any concerns or suggest changes. Records of these meetings showed people engaged well with the process.
- The provider had implemented a 'You said, we did' board in the entrance of the building. This detailed how people's views and concerns had been acted on and improvements made.
- Relatives they felt involved and updated by the provider. One relative said, "They're really, really good. They look after relatives and are very welcoming."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People weren't always able to choose when they woke and received support in the morning. We found the majority of people were awake by 08:00; whilst some people told us they preferred to wake early, others said they weren't given a choice. One person told us, "At 05:00 they say they've come to give you a wash. I don't get a choice, it would upset the whole program."
- We received mixed feedback from staff about the morning routine at Delves Court Care Home. Most staff informed us that people were only supported to wash and dress when they were ready. However, some staff told us they were encouraged to support people with their personal care if they were helped to reposition from 06:00 onwards.
- People didn't always receive continence care in line with their needs. At the time of our inspection we found 1 person had run out of suitable continence aids. Another person was being supported to use continence pads when they were able to use the toilet with assistance. This meant people's needs weren't met in a person-centred way, which risked compromising their dignity.
- People didn't always receive support that was personalised to suit their needs. For example, we observed a person having a medication patch applied to their skin while they sat with others at the breakfast table.

The provider had failed to ensure people had maximum choice and control over their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People weren't always supported to have the equipment they required to support their communication. We observed that 1 person had not had batteries to power their hearing aid for at least 2 days. This meant they were unable to engage fully with those around them.
- Care plans considered people's individual communication needs. For example, records detailed what support people with sensory impairments needed to communicate with others. However, these weren't always followed, such as for the person who didn't have a functioning hearing aid.
- The provider had identified that a pictorial menu of meal choices was required. This was being formulated

using photographs of the meals on offer, so people could make informed choices. The provider was hoping to have this available for people imminently.

End of life care and support

● People had care plans in place to consider their individual wishes, values and beliefs at the end of their lives. Respect forms were completed which detailed people's wishes for emergency care.

● Staff had received training on end of live care. However, some staff lacked knowledge about what signs indicated a deterioration for a person at the end of their life.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported with individual and group activities. There were activity coordinators employed to support people to engage in meaningful activities. We observed people enjoying activities in groups and one to one activities for people cared for in bed.

● People's life history, interests and hobbies were considered by the activity coordinators to identify meaningful activities. A relative told us how their loved one had recently been supported to go out into the community and had thoroughly enjoyed it.

● People and relatives spoke highly of the activity coordinators and the support they offered. One person with a sensory impairment explained, "I love the activity [coordinators] as they do activities and I can take part. They talk me through things and get me involved; they never leave me out. They always make sure they come and chat and cheer me up."

Improving care quality in response to complaints or concerns

● The provider had a system in place to record, investigate and respond to complaints received. We saw that any issues raised had been explored and addressed appropriately.

● Feedback from people, relatives and professionals was sought. The results from questionnaires were analysed and actions in relation to the findings were documented.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Quality assurance systems had failed to identify the areas of concern we highlighted during our inspection. Audits had not been effective in finding the issues we established in relation to the safety and quality of the service.
- Processes to monitor the dependency needs of the service did not reflect our observations and feedback we received about staffing levels at the service. Governance systems failed to make adequate arrangements for the clinical oversight of nursing care provided to people.
- Audit systems were not effective in identifying shortfalls in the administration and recording of people's prescribed medicines. This meant we could not always be assured that people had received their medication correctly.
- Systems were not effective in identifying failings in person-centred care at the service. The provider conducted audits, including out of hours visits, but these had not highlighted the shortfalls identified during the inspection.
- The provider's processes had not ensured care plans and risk assessments were consistently reviewed and updated to provide key information about people's needs. This included the issues we identified in people's records relating to wound care, weight loss and people's capacity. The provider was aware of a general shortfall in the quality of care plans and was looking to implement an electronic system.

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People, staff and relatives spoke positively about the registered managers and felt able to raise any issues with them. One staff member said, "[The registered managers] are both lovely. Their door is always open and we can always talk to them."
- Professionals reported the service worked well in partnership with them and found the staff and managers responsive to any professional advice or guidance.
- Systems were established to seek feedback from people, family and visitors to the service. We saw previous feedback had been analysed and was positive about the service people received.

Continuous learning and improving care

● The provider had an ongoing improvement action plan that was reviewed monthly. Our observations reflected the actions recorded as completed on the document. For example, the provider had returned any overstock of medication and ordered some replacement equipment that was becoming worn.

● There was a system in place for responding to feedback from people, relatives and stakeholders. For example, the service had recently implemented a resident newsletter in response to feedback gathered.

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 registered managers had a clear understanding of duty of candour and their statutory responsibilities to notify CQC of certain incidents and events.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people's rights were protected. This was a breach of Regulation 11 (Need for consent) 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
Treatment of disease, disorder or injury	The provider had failed to ensure people had maximum choice and control over their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	We found no indication that people had been harmed. However, systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure sufficient numbers of suitably qualified staff were deployed to meet people's needs. This put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

Impose a condition.