Blackwater Mill Limited

Blackwater Mill Residential Home

Inspection report

Blackwater
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Blackwater Mill Residential Home is a care home providing accommodation for up to 60 people in one building, some of whom are living with dementia. At the time of our inspection, there were 53 people living in the service. Blackwater Mill provides all single bedrooms and a range of communal facilities.

People's experience of using this service and what we found
Whilst improvements had been made since the previous inspection in July 2021 we found quality assurance systems had not been used effectively to identify areas for further improvement we noted during this inspection. At this inspection breaches of regulations were found including repeat breaches in relation to quality assurance, risk management and notifications. The key question Safe has consistently been rated requires improvement for the past 6 inspections.

The provider had failed to ensure CQC was notified about all incidents as required and the Duty of Candour had not been fully followed.

Individual risks to people had not all been assessed, recorded and updated. Environmental risks had also not all been fully assessed and actions identified to manage environment risks had not always been followed.

Systems were in place so that medicines were administered safely and as prescribed although we identified some further areas for improvements.

There were enough staff [care and ancillary staff] to support people's needs in a timely and unhurried way. Appropriate recruitment procedures had been followed to help ensure only suitable staff were employed. Staff had received training and support to enable them to carry out their role safely.

Infection prevention and control measures were in place and followed government guidance.

There were appropriate policies and systems in place to protect people from the risk of abuse and the registered manager and staff understood the actions they should take to keep people safe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and their family members gave us positive feedback about the home and told us that staff were kind and caring. We observed positive interactions between staff and people.

People, their family members and external professionals said the registered manager was approachable

and supportive. Staff were also positive about the registered manager.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was requires improvement (published 11 August 2021) and there were breaches of regulation. The service remains rated requires improvement.

Why we inspected
We carried out an unannounced comprehensive inspection of this service in July 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve risk management, governance and to ensure CQC were notified about all incidents as required.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained the same Requires Improvement.

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

Enforcement and Recommendations
We have identified breaches in relation to quality monitoring, risk management, notifications and Duty of Candour at this inspection.

We have added a condition to the providers registration requiring them to undertake regular formal quality monitoring and submit a monthly audit and action plan to CQC.

Please see the action we have told the provider to take at the end of this report in respect of the failure to notify CQC of injuries which required medical attention and failure to follow the Duty of Candour.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Blackwater Mill Residential 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 was completed by one inspector and an Expert by Experience who made phone calls to family members of people living at the service. 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
Blackwater Mil Residential 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. Blackwater Mill Residential Home is a care home without 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 was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 20 January 2023 and ended on 31 January 2023. We visited the location on 20 and 27 January 2023.

What we did before the inspection
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 took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. This included inspection reports, action plans submitted by the provider and notifications. Notifications are information about specific important events the service is legally required to send to us. We used all of this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service and 9 family members about their experience of the care provided. We received feedback from 4 external professionals. We spoke with 14 members of staff including the registered manager, deputy manager, care staff, activity staff, administration staff, catering staff, housekeeping staff, maintenance staff and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We observed care being provided within communal areas of the home and viewed the home and garden. We reviewed a range of records. This included 5 people's care records and multiple medication records. We looked at 5 staff files in relation to recruitment and a variety of records relating to the management of the service. These included records of checks completed on the fire detection systems, training data, policies and procedures, records of accidents or incidents and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires Improvement. At this inspection the rating has remained 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.

Assessing risk, safety monitoring and management
At the last inspection completed in July 2021 inspectors identified that risks associated with people's care were not consistently assessed and documented. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 12

● Most individual and environment risks had been assessed and plans put in place to manage identified risks. However, some of the environment risk assessments had been completed by the nominated individual for several services and were not specific to Blackwater Mill. This meant specific risks had not been adequately assessed with actions taken to mitigate the risk they posed. For example, risks posed by a flight of steep stairs adjacent to an area where we observed people tended to congregate near the home's entrance. A staff member told us, "I do worry about those stairs they are steep, and people could fall down them."
● Not all actions identified in the general environment risk assessments had been followed. For example, we identified electric radiators had been used as additional heating during recent cold weather. The risk assessment stated these radiators would be guarded. We noted an in use electric radiator in the communal lounge which was hot to touch and was not guarded meaning people were at risk of injury if they touched this. We saw another in use unguarded electric radiator in a person's bedroom. We identified some other risk assessments had not been completed or were not specific to Blackwater Mill. These included risks posed by other staircases people could access and pet chickens and cadged birds living at the service. We brought this to the attention of the registered manager who took prompt action to remove these radiators and complete additional risk assessments.
● An external specialist had completed a fire risk assessment in early January 2023. This had identified some immediate actions which the registered manager was completing. However, we noted some actions had been identified at a previous inspection and were only now being actioned. Which meant the risks to people had not been addressed meaning any possible action to manage risks may not be taken.
● Following an unwitnessed fall, it is important to monitor people for up to 72 hours to help identify if they develop symptoms indicating a head injury so that prompt medical support can be obtained.
We noted a person had an unwitnessed fall in January 2023 however, the records of post fall monitoring could not be located. The nominated individual and other senior staff were unclear as to how to initiate

these checks on the electronic care management system in use. They were unable to supply any records of post falls head injury observation checks having been undertaken. The registered manager told us they had subsequently initiated a paper recording tool.
●,Some people were prescribed blood thinning medicines. Risk assessments were not always in place to provide guidance on the management of risks associated with these medicines. Where risk assessments had been completed additional detail was required. The registered manager acted promptly when we identified additional risk assessments for individual people were required.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate individual and risks posed by the homes environment were effectively managed. 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) Regulations 2014.

The registered manager and nominated individual told us they would individualise environment risk assessments or put in place additional risk assessments we identified as being required. Examples were subsequently received from the nominated individual.

● Other risks relating to individual people had been assessed and recorded, along with action staff needed to take to mitigate the risk. For example, risk assessments were in place for people at risk of falling, medicines management, skin integrity, nutrition, dehydration and mobility. Daily records of care, observations in communal areas and discussions with staff showed staff were following risk mitigation measures. For example, a person was at risk of choking and required their drinks to be slightly thickened. A care staff member was able to describe how the person's drinks should be prepared and where fluid thickening powder was stored.
● Records showed equipment was monitored and maintained according to a schedule. In addition, gas, electricity and electrical appliances were checked and serviced regularly.
● Fire detection systems were checked weekly although the records for checks completed in December 2022 could not be located. Personal emergency evacuation plans had been completed for each person detailing action needed to support people to evacuate the building in an emergency. Staff were aware of the actions they should take if the fire alarms sounded.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Using medicines safely
● People's medicines were not always managed safely.
● For people prescribed 'as required' [PRN] medicines the outcome of taking these medicines had not

always been recorded. Recording the effectiveness to these medicines would help ensure that they were appropriate for the presenting problem and mean medical professionals would have relevant information when reviewing medicines.
● A medicines audit completed in December 2022 had involved counting stocks of medicines and cross referencing this against the stock levels the electronic medicines administration system stated should have been in place. This indicated that for some people additional stocks were held and for others less than the required numbers of tablets were in place. We asked the nominated individual and registered manager what action had been taken to ensure stock levels were correct to check people had received their medicines as prescribed. They responded that they felt the discrepancy had been due to changing pharmacy. However, regardless of the move to a new pharmacy the numbers of tablets received into the home and those recorded as administered or wasted should tally. A further audit had occurred in January 2023. This also identified discrepancies in stock levels. We could not be assured people had received the medicines they required.
● Staff monitored fridge and room temperatures where medicines were kept, checking medicines were stored within safe temperature ranges. For fridges these temperatures were appropriate however, we noted that for medicines stored at 'room temperatures' records were consistently showing higher than safe temperatures were occurring. This had not been identified by the staff undertaking the daily temperature checks or during medicines audits. No action was taken until we identified and discussed this with staff. New thermometers were purchased as it was thought the existing ones may be unreliable. Medicines stored at incorrect temperatures can become ineffective.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure all aspects of medicines management were effectively managed. 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) Regulations 2014.

● Systems were in place to ensure that when additional medicines such as antibiotics were prescribed, these were obtained promptly meaning there were no delays in commencement of administration.
● Staff had been trained to administer medicines and had been assessed as competent to do so safely. The provider's procedure ensured this was reassessed at least yearly using a formal approach.

The registered manager acted promptly to address the issues we identified with medicines management.

Staffing and recruitment
● People were supported by appropriate numbers of consistent, permanent staff who they described as kind and caring.
● People told us they felt there were enough staff who knew how to support them. One person said, "They're [staff] very good, very nice. They know what they're doing." A family member told us, "The carers are very loving and caring and if [person] is upset they will support her. She is still a bit unsettled. She likes to be independent and loves her clothes. They allow her to dress herself but if she puts something on inside out they don't make a big fuss they just help her to put it on correctly." Another family member told us, "The staff are all great, she is a very difficult lady to look after but they are very professional, very cheerful and treat her with respect."
● Care staff told us they felt there were enough staff. One staff member told us, "We have time to do everything we need to do." They also confirmed two staff were always available when required for people who needed a higher level of support such as with moving and repositioning. Staff were seen to have the time they required to provide people with care in a relaxed and unhurried way.

● Staffing levels were determined by the number of people using the service and the level of care they required. Short term staff absences were covered by existing staff members or members of the management team which helped ensure continuity of care for people.
● Recruitment procedures were robust, to help ensure only suitable staff were employed. This included disclosure and barring service (DBS) checks, obtaining up to date references and investigating any gaps in employment. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Prompt action was taken when we identified a reference from an applicant's last care employer had not been requested although other references for this staff member were in place.

Systems and processes to safeguard people from the risk of abuse
● Appropriate systems were in place and followed to protect people from the risk of abuse.
● People and their family members all said they felt safe using the service. A person told us, "Safe, yes I feel safe, the staff are nice." When asked if they felt their family member was safe, we received the response, "He has 2 carers to attend to him so that keeps him safe. The staff are always very attentive with him. I know he feels safe and secure because not once has he asked to come home. That makes me feel comfortable."
● Staff had received safeguarding training. One staff member described the actions they would take if they witnessed or suspected abuse may have occurred. They told us, "If I had concerns, I'd go to [registered manager]. I could also go higher in the company." Staff were less clear about reporting concerns outside the service and the registered manager agreed to remind staff of their options in respect of this. We did note this information was available to staff on various notice boards around the home. By the second day of the inspection all staff were fully aware of their reporting responsibilities and told us this had been reinforced during handovers.
● The registered manager and nominated individual understood their responsibilities in respect of safeguarding. They detailed appropriate actions they would take if a safeguarding concern was raised to them and confirmed they had undertaken safeguarding training. When safeguarding concerns had been raised to them the registered manager had reported these appropriately to the local authority safeguarding team.

Preventing and controlling infection
● Discussions with the registered manager showed they were aware of government guidelines in relation to the management of risks relating to COVID -19 and other infections.
● We were assured that the provider was responding effectively to risks and signs of infection.
The provider's infection prevention and control policy was up to date. Appropriate arrangements were in place to control the risk of infection including COVID-19. The home's policies and procedures reflected the latest best practice guidance from the Department of Health.
● We were assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. Staff had been trained in infection control techniques and had access to personal protective equipment, including disposable masks, gloves and aprons, which we saw they used whenever needed. People and family members told us staff always wore masks. Prompt action was taken when we identified concerns with the storage of waste including PPE pending collection and removal.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was accessing testing for people using the service and staff. The registered manager was aware of when they should ensure people or staff undertook COVID - 19 testing and what action they should take if a positive result was received.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. People and family members said they felt the home was clean. One person told us, "Yes, it is very clean, all the time." A family member said , "I have been to his room and it is always spotlessly clean." The

home appeared clean and housekeeping staff completed regular cleaning in accordance with set schedules. Staff confirmed this and told us they had time to complete all necessary cleaning.

● We were assured that the provider was admitting people safely to the service.

● The registered manager described the actions they had taken following the home having been awarded two stars for food hygiene by the local authority food hygiene inspectors. A subsequent visit by environmental health inspectors in September 2022 noted all necessary actions had been completed.

Visiting in care homes

Safe systems were in place to enable people to receive family or other visitors. Family members confirmed they were able to visit whenever and as often as they wished to do so and, could take people on outings away from the home.

Learning lessons when things go wrong

● Where an incident or accident had occurred, there was a record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents.

● The electronic care planning system automatically allocated all accidents and incidents for review by the management team. The system also enabled an audit of the accidents and incidents to be undertaken so that patterns or trends could be identified such as time or location of accidents.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership 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. Continuous learning and improving care

At the last inspection completed in July 2021 inspectors found that the providers quality monitoring systems were either not in place or robust enough to ensure people received a safe service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider's quality assurance processes were not fully effective. During the inspection we identified areas which required improvement which are detailed in the safe and well-led sections of this report. These concerns had not been identified by the provider or registered manager via their audits and oversight procedures. The delivery of high-quality care was therefore not assured by the governance procedures in use.
● The key question safe has consistently been rated requires improvement for the past 6 inspections.
● The nominated individual told us they attended the home 2 days a week and monitored the service at other times via the electronic care planning system and by frequent contact with the registered manager. However, they had not identified the failure to follow the Duty of Candour or that some notifications were not being submitted as required. They had also not identified that environmental risk assessments were either not being followed or were not individualised to Blackwater Mill. Meaning effective risk management was not always in place. The fire risk assessment undertaken by an external specialist in January 2023 noted that some actions identified in the previous external fire risk assessment in July 2021 had not been completed. This meant risks to people's safety had not been identified by the providers oversight and governance procedures.
● The electronic care planning system was unable to demonstrate that all individual risks had been assessed and suitable mitigation measures put in place. It had also not been identified that following unwitnessed falls required monitoring was occurring. Action to further monitor medicines stock levels had not been taken following multiple discrepancies being noted on a medicines audit completed in December 2022 or January 2023.
● The provider contracted with a company which provided a full range of policies and procedures as well as supporting documents to aid the smooth running of the service. However, these had not been fully utilised

or followed. The failure to implement the provider's policies and procedures placed people at risk of receiving unsafe care and treatment.
● The service had an improvement plan. This did not include dates for when new actions were added to it meaning that it was not possible to establish when concerns had been identified. We raised this with the registered manager who retrospectively added dates. Where risks had been identified on the improvement plan prompt action had not always been taken. For example, it had been identified in September 2022 that stairs within the home posed a risk to service users. However, no action to individually assess each staircase and take interim measures to reduce risks had occurred.

The provider's quality monitoring and governance procedures have failed to improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where we identified improvements were required the registered manager and nominated individual took immediate action and committed to making the necessary improvements.

At the last inspection completed in July 2021 inspectors identified that the provider had failed to notify CQC as required of all safeguarding concerns. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Registered persons are required to notify CQC of a range of events which occur within services. The provider had not ensured that CQC had been notified about all injuries which had required treatment by a healthcare professional.

We found no evidence that people had been further harmed by the failure to notify CQC however, the failure to notify CQC of serious injuries was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

● Other notifications had been received as required.

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 duty of candour requires the service to apologise, including in writing when adverse incidents have occurred. The registered manager said they had not provided a written response and was unaware that a written response was required under the duty of candour and confirmed they would now be fully following their procedures in the future.

We found no evidence that people had been harmed by the failure to follow the Duty of Candour requirements of a written explanation and apology however this was a breach of regulation 20 (Duty of candour) of the health and Social care Act 2008 (Regulated Activities) regulations 2014 (Part 3)

● The registered manager demonstrated an open attitude throughout the inspection and this was also the view of visiting health and social care professionals. Whilst discussing some recent incidents and concerns they showed they had been open with the person or, where appropriate, family members about what had occurred and what was now in place to reduce the likelihood of repeat incidents.

● A family member told us the registered manager had kept them informed following a fall and felt able to approach the registered manager if they had wanted any further information.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and their family members were overall happy with the service provided at Blackwater Mill. One person told us, "I've been here several years and I'm happy here." Another person said they received "good care" and they "felt safe". A family member said, "I think the care seems more intense since [registered manager] arrived. They are quite focused on the residents". Another family member commented about the registered manager saying, "She seems very efficient and has tackled a lot in a short space of time. She doesn't miss much."

● People told us they had never had to raise any concerns but were aware of who the registered manager was and would feel comfortable doing so should the need arise. Family members also confirmed they knew who the registered manager was and felt able to approach her should the need arise. One family member said, "I met her [registered manager] when my [relative] first went in and have spoken to her on the phone. She is always helpful and recognised that I might need help in sorting things when [relative] first went in. I would have no problem in raising issues with her."

● People, family members and staff said they would recommend the home as a place to live. For example, one family member said, "The home is great and I would certainly recommend it. There is a lovely atmosphere there and he doesn't go without anything."

● People, family members and external professionals felt able to approach and speak with the registered manager or other staff and were confident any issues would be sorted out. Pleasant interactions were seen between the registered manager, people and staff throughout inspection. People appeared to be comfortable with care staff who had built good relationships with people.

● Staff were proud of the service. All said they would recommend Blackwater Mill as a place to work and would be happy if a family member received care there.

Working in partnership with others

● Family members told us they had been kept informed and felt able to approach staff or the registered manager if they had wanted any further information.

● External health and social care professionals were positive about the service and all felt able to raise any issues or concerns with the management team and were confident that these would be resolved. For example, one external professional told us the registered manager was "very responsive to finding solutions", "any question will get an answer" and "willing to seek and follow advice".

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that CQC had been notified about all injuries which had required treatment by a healthcare professional.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered person had not ensured actions required under the duty of candour had been fully followed.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate individual and risks posed by the homes environment were effectively managed placing people at risk of harm. Systems were either not in place or robust enough to ensure all aspects of medicines management were effectively managed.

The enforcement action we took:

We have added a condition to the providers registration requiring them to undertake regular assessments of individual and environmental risks and submit a monthly audit and action plan to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality monitoring and governance procedures have failed to improve and sustain the quality and safety of the service.

The enforcement action we took:

We have added a condition to the providers registration requiring them to undertake regular formal quality monitoring and submit a monthly audit and action plan to CQC.