Ashfield Care Homes Limited

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Inspection report

99 Ashley Road
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16 August 2023

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Ashfield Care Homes Limited, 99 Ashley Road is a residential care home providing personal care to 6 people at the time of the inspection. The service can support up to 10 people.

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

Right Support
People were not always supported to have maximum choice and control of their lives and staff did not always 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. The environment was cramped and not suitable for people who used wheelchairs. Corridors were narrow and we observed 1 person trying to get around a corner and needing help. The dining area was cramped and did not allow sufficient space for the 4 people who used a wheelchair to eat with enough personal space. There was no room for others to eat in the dining area at the same time, had they wished to. The registered manager said they would turn an upstairs bedroom into a lounge/dining room for the person that lived upstairs, along with a second person who was mobile. However, this did not offer meaningful choice and could lead to isolation and exclusion and did not resolve the small, cramped dining area downstairs. In response to our feedback about the limited space available in the dining room, the provider removed the breakfast trolley to increase the space available. In the longer term the provider told us they were planning to extend the current dining space.

Right Care
Some aspects of people's support were person centered. For example, 1 person was being supported with the aim of them moving into supported living when they were ready. However, we observed some institutionalised and restrictive practice which did not promote people's independence, dignity, privacy and human rights. For example, 1 person waited around the front entrance hall for much of the morning wanting to go out but was told they would need to wait until the driver got back and then everyone could go out together. Staff told us there was only 1 driver on shift which made it difficult to support people to go out. One person had their back to the wall with a table in front of their wheelchair. The registered manager told us the person was able to propel themselves backwards or push the table away from them. However, no staff were in the lounge to help the person manoeuver if they got into difficulty which meant there was a risk the person would not be able to move freely. Another person was told to sit down, and staff put their hands on the person's shoulders to emphasise this without discussing the person's wish to stand up. The

environment was in a poor state of repair with rubbish and disused items left in the garden areas. The home was dirty and unloved which did not respect the fact it was peoples' home. Shared areas were not very homely or personalised.

Right Culture
Staffing levels did not always enable people to live inclusive and empowered lives. There were not enough staff hours rostered to ensure people received their assessed 1 to 1 support hours. Activities were often shared and based around staff availability rather than personal preferences. Care practice was very mixed depending on people's abilities. Whilst 1 person was able to live quite independently, others were not. For example, 1 person wanted a coffee at 10.46 am and was told by staff it was nearly 11.00 (coffee time) when they would make one for the person.

We identified concerns with medicines management and administration and staff practice. Staff lacked knowledge of emergency procedures relating to people medicines and health conditions. This put people at risk of harm.

The provider had systems in place to monitor the quality and safety of the home. However, these were not always effective in identifying shortfalls which put people at risk of harm and/or poor outcomes.

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 June 2021)

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

We have made a recommendation about the recruitment of agency staff.

Why we inspected

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.

We carried out an announced comprehensive inspection of this service in May 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 safe care and treatment and good governance.

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 changed from requires improvement to inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashfield

Care Homes Limited on our website at www.cqc.org.uk.

Enforcement

At this inspection we have identified breaches in relation to safe care and treatment; dignity and respect; person centred care; good governance; staffing; safeguarding people from abuse; and the requirement to display ratings. We also identified the provider was not meeting the requirements of Right Support, Right Care, Right Culture.

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 request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Ashfield Care Homes Limited

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 3 inspectors.

Service and service type
Ashfield Care Homes Limited (99 Ashley Road) 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. 99 Ashley Road 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
We gave the service 16 hours' notice of the inspection on 27 July 2023. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us. The inspection on the evening of 16 August 2023 was unannounced.

Inspection activity started on 27 July 2023 and ended on 17 August 2023.

What we did before the inspection
We reviewed information we had received about the service since the last 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 used all this information to plan our inspection.

During the inspection
We spoke with 4 staff and 3 people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions with people. We spoke with 2 relatives and received feedback from 3 social care professionals. We met with the registered manager, area manager and nominated individual to discuss our findings.

Inadequate

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 changed to inadequate.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) 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 12.

Assessing and managing risk.

- Risks to people's safety had not always been identified and managed which meant they were at risk of harm. Staff advised 1 person needed to always have a member of staff around due to a health condition, however they also advised this wasn't always possible. The registered manager had told us on the first day of inspection the person needed someone with them unless they were in bed. They also told us there needed to be a staff member in shared areas whenever the person was there. Their reviewed profile document stated, "I must never be left alone, unless I am in bed".
- We observed multiple periods of time where there were no staff members present in the lounge when the person was there. Staff told us, "It's a risk [low staffing levels]," and "We manage the best we can, but it can be a concern sometimes."
- The person was also prescribed a blood thinning medicine which meant they were at risk of excessive bleeding if they had an injury. We asked staff what the process was if the person had an unwitnessed seizure or hit their head during a seizure. They were not able to tell us and did not indicate an understanding of what was being asked.
- There were numerous maintenance tasks outstanding which posed a risk of injury to people. For example, a disused cable hanging down and coiled on the floor in the lounge created a trip and potential ligature hazard. We discussed this with the registered manager on the first day of our inspection, but it was still there when we returned on 16 August. Discarded items, including a mattress and empty paint pots, were left around the garden areas and a garden chair partially blocked a wheelchair ramp. An item of furniture was stored under the staircase. This posed a risk to the evacuation route in the event of a fire. This was discussed with the registered manager at our last inspection.

Failure to identify, monitor and manage people's individual and environmental risks was a breach of Regulation 12, safe care and treatment, of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not always managed safely. We found a number of concerns which meant we were not

assured people were kept safe from harm of poor practice.
● The medicines cabinet was left unlocked, wide open and unattended on at least 4 occasions during our inspection, despite staff having been prompted by inspectors.
● Staff and the registered manager told us staff needed permission to administer 'when required' or PRN medicines. This meant they would need to contact the on-call manager out of hours. For example, one person's PRN medicine administration chart directed staff to administer a medicine in a crisis. During our second site visit, conducted in the evening, we attempted to call the on-call manager twice between 8pm and 9pm and received no response. Staff were not clear on who to escalate to and we had to contact another of the provider's care homes. We were concerned this would mean a delay in a person receiving their medicines if required out of hours, putting them at risk of harm.
● When medicines were prescribed 'when required', there was not always guidance for staff about why, when and how these should be taken. This meant people may be at risk of not receiving their medicines correctly.

Failure to manage medicines safely was a breach of Regulation 12, safe care and treatment, of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

● The provider had policies and procedures for the management and administration of medicines. Staff received training and competency assessments to ensure they remained competent to carry out these duties.
● A relative told us they were happy with the way staff managed their family member's medicines and kept them informed of any changes.

Preventing and controlling infection
● The provider had not maintained a clean and safe environment. At our last 2 inspections, we raised concerns about poor cleanliness and peeling surfaces and furniture which created an infection risk. At our inspection in May 2021, we found the provider was in breach of Regulation 12, safe care and treatment, of the Health and Social Care Act (Regulated Activities) Regulations 2014. While some action had been taken, for example replacement of ripped easy chairs and repainting of some surfaces, at this inspection , unsafe and poor infection, prevention and control (IPC) practice remained.
● An IPC audit had been carried out on the morning of 27 July 2023, which showed everything had been checked and no concerns were identified. This was not what we found later that morning.
● A windowsill, banister post and the front door were black with built up dirt. Damage to surfaces in a bedroom and bathroom made them porous which meant they could not be hygienically cleaned. There were hairs and dirt around the base of a hand-rail by a toilet which had not been cleaned. The area around the drain plug in the wet room was black with build-up of wet grime.
● We observed staff did not always use personal protective equipment (PPE) when assisting people with personal care. This posed an infection risk.

Failure to maintain a safe standard of infection, prevention and control was a breach of Regulation 12, safe care and treatment, of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

● Staff completed checks on equipment such as the bath and wheelchairs. Equipment seemed in good order. Small electrical appliances and fire-fighting equipment had been checked and approved for safety.
● Legionella monitoring and management had improved from our last inspection. Checks were completed and recorded by staff and the manager who had received further training.

At our last inspection we found the provider to be in breach of Regulation 18 of the Health and Social Care

(Regulated Activities) Regulation 2014, as the provider had not ensured staff were suitably qualified and competent. Training had now been addressed. However, at this inspection we found the provider had not deployed enough staff to meet people's needs and therefore remained in breach of Regulation 18.

Staffing and recruitment

● During our inspection, we found there were not enough staff to provide person centred support, to meet peoples' assessed needs and keep them safe. The staff rota showed there were not enough staff to meet people's support hours as assessed in the provider's dependency tool. This included 1 to 1 support hours and shared support (core) hours. This meant people did not consistently receive the level of support they required.

● For example, a staff member told us on 27 July 2023 there was a lack of drivers, and this was a challenge. The driver on duty had gone out with a person in the home's transport, and 2 staff members and the registered manager had remained at home to support the other 5 people. We observed people did not receive any meaningful interaction or 1 to 1 support during this time. One person had been waiting in their wheelchair by the front door for much of the morning wanting to go out. A staff member told us everyone would have to wait until the driver came back and they could all go out together in the home's transport.

● One person required 1 to 1 support at mealtimes. However, we observed a staff member sitting with the person while eating whilst also supporting another person. They had asked, "Would you like your cereal yet? I am going to be sat here for a while, I am not forcing you but now is a good time as I can sit next to you". The same staff member told us, "It's only been possible [to sit with them] because everyone else has finished eating and [the other person] is there so someone is sat with her". This put the person at risk of not meeting their dietary needs.

Failure to ensure there were sufficient staff deployed to meet people's assessed needs and keep them safe was a breach of Regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us they were happy with the level of support their family members received. A relative said, "She seems very happy. She goes out and has quite a lot of interaction." Another relative told us, "They're bound to bring him to a local pub for lunch. We go to see him, and they take him in minibus to come and meet us."

● Social care professionals did not raise any concerns with us about staffing.

● The provider had procedures to recruit staff safely. We reviewed the 2 newest staff member files and found each had completed an application form including an employment history. One history was completed with only years rather than months and years, and there was a gap in employment which had not been explored. This was addressed during the inspection. We also saw there was no staff profile for 1 agency staff member. Other checks had been completed, such as proof of identity, employment references and Disclosure and Barring Service checks, which help employers make safer recruitment decisions.

We recommend the provider refers to Schedule 3 guidance in relation to agency recruitment to ensure they meet the requirements of the role.

Safeguarding people from abuse

● The provider had systems in place to safeguard people from abuse. This included a safeguarding policy and training for staff. Staff told us they knew how to identify and report abuse and which external agencies they would report to if needed. The registered manager had made safeguarding referrals to the local authority in cases where concerns had been identified.

● However, we observed several incidents where a person was told to sit down, or a staff member put their hands on a person's shoulders to prompt them to sit down without discussing the person's wishes to stand up. We also observed a person with their back to the wall and table in front of them. The registered manager told us the person was able to propel themselves backwards or push the table away from them. However, no staff were in the lounge to provide support and help the person manoeuvre if they got into difficulty which meant there was a risk the person would not be able move freely.

Failure to protect people from the risk of abuse was a breach of Regulation 13, safeguarding people from abuse, of the Health and Social Care Act regulations 2008 (Regulated Activities) Regulations 2014.

● Relatives we spoke with did not have any safeguarding concerns. One relative told us, "We see the way they engage with him. It's totally reassuring".

Learning lessons when things go wrong

● Staff completed a report following any incidents or accidents, and appropriate actions taken. These were collated, although no formal log was held as the home was small and these could be easily reviewed and acted upon.

● However, we were not assured the registered manager learnt lessons and effectively acted upon concerns raised at our previous inspection or in previous audit reports.

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. Appropriate legal authorisations were in place to deprive some people of their liberty, and the registered manager had a system in place to monitor and apply to the local authority when these required renewal.

Visiting in care homes

The provider had no restrictions on visiting at the time of inspection. This is in line with Government guidance where there is no infection outbreak.

Inadequate

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 changed 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.

At our last inspection we identified there were numerous shortfalls in the monitoring and assessing of safety and quality. This was a breach of Regulation 17, good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider remained in breach of the Regulation 17.

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

- The provider had a series of audits in place for monitoring and assessing the quality and safety of the service. However, they had not identified the issues we found, or where they had, these had not been addressed.
- For example, conflicting information in 1 person's support plan and risk assessment meant staff did not have clear guidance on how to support them safely. This put them at risk of harm.
- The provider's audits had not identified the unsafe storage of COSHH products, or that the registered manager had not followed the provider's own COSHH policy. They had also not identified the poor state of cleanliness and infection risk within the home. Areas of the premises were not visibly clean and created an infection risk. Additionally, environmental shortfalls, including peeling paint and furniture surfaces prevented effective cleaning. These shortfalls had been identified during 2 previous inspections and placed service users at increased risk of harm.
- The provider's on-call procedure was not clear or effective. The registered manager had not identified staff lacked knowledge of escalation procedures, which put people at risk of harm.
- An audit on 6 April 2023 identified shortfalls we found in relation to PRN protocols. However, this had not been effectively addressed and issues remained at our inspection.
- Audits had failed to identify environmental shortfalls we found during our inspection. This meant there was a lack of appropriate respect for peoples' home environment which compromised their safety and dignity.

Failure to monitor, assess and manage risk and quality performance, and the failure to learn and improve, and the failure to maintain an appropriate standard of environment was a breach of Regulation 17, good governance, and of Regulation 10, dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had not displayed the up to date rating certificate in the home. This was raised on the first day of inspection and had not been changed when we returned on the second day.

Failure to display the current rating was a breach of Regulation 20A, display of ratings, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
● We were not assured people were empowered in all areas of their lives.
● The provider's audit, dated 6 April 2023, incorrectly confirmed the service was working in line with statutory guidance: 'Right Support, Right Care, Right Culture.' This is not what we found during our inspection.
● The provider had not considered the statutory guidance 'Right Support, Right Care, Right Culture,' in relation to the premises. People had personalised their bedrooms with accessories of their choice, including posters, bedding and curtains. However, there was little evidence to show people had been consulted about their preferences in relation to environmental décor, including consideration of any sensory needs in the shared areas. Following our feedback, the provider sent a maintenance plan which included a plan for consultation with people on redecoration of their bedrooms and shared areas of the home.
● A refurbished dining area had 2 small half-moon tables, and the area was cramped when people were in their wheelchairs at mealtimes. There was no room for 2 people, who were mobile, to share in the mealtime experience if they wished to.
● The registered manager told us as a temporary measure, they would turn an unused bedroom upstairs into a lounge with a dining table for the 2 mobile service users. This meant there would be little choice for them in where they wanted to eat and could lead to feelings of isolation and exclusion and did not resolve the issue of the cramped downstairs dining room.
● The shared lounge was functional but not homely. One person sat in their wheelchair in the middle of the room as there was no space for them to sit anywhere else.
● There were some institutionalized practices. For example, when a person asked about a coffee at 10.46 a staff member told them it was nearly 11 o'clock, coffee time, then would make one. We saw many instances when people were sat in the lounge with no meaningful activity or staff interaction. Activities were often based on staff availability and were often shared experiences, rather than individual preferences, such as everyone going to the pub for lunch. The registered manager told us everyone needed support to go out and this could be shared.

Failure to consistently provide person centred care and meaningful choice was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In response to our feedback about the limited space available in the dining room, the provider removed the breakfast trolley to increase the space available. In the longer term, the provider said they were planning to extend the current dining space.
● Feedback from relatives and people was positive about the support received. Two people responded positively, smiling and nodding when we asked them if they liked living at 99 Ashley Road. Another person told us they were settling in well and liked living at the home. We saw some positive interactions between staff and the people they supported.

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 understood their responsibilities to notify relevant persons when required under the duty of

candour legislation.

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

● The provider completed surveys and feedback from relatives was positive and confirmed they felt involved and kept informed of their family members' care.

● Staff were positive about working at 99 Ashley Road, with all participants stating they felt supported by the manager who was approachable.

● People had completed the surveys with the assistance of staff. These were very positive and people said they felt safe and treated well. A recent audit identified that service user meeting format could be changed to improve communication and ensure meaningful outcomes for people. This was in progress.

Working in partnership with others

● The staff worked with other partners, such as district nurses, care managers and the community. Social care professionals told us the staff and manager were approachable and knowledgeable. Comments included, "Always had timely and appropriate responses with manager" and "The manager will inform me if they have any concerns about TS, this is either via email or a phone call. The manager has been open transparent with their communication" and "I can say there has been positive communication with them".

● A pet therapist attended the home regularly and brought small animals such as rabbits and guinea pigs, which they told us everyone loved. We saw there was a good rapport between them and the manager.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people were empowered to have meaningful control over their lives and consistently provide person centered care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured the home was maintained in a way to respect peoples' dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to identify restrictive practices in relation to people's freedom of movement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider failed to display their up to date rating.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure there were enough staff to meet peoples' needs and keep them safe.

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 The provider had failed to ensure the service was safe and risks were assessed and managed in relation to medicines, IPC, the environment and staffing.

The enforcement action we took:

We issued a warning notice against the provider and registered manager for the failure to provide safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain oversight of the safety and quality of the service.

The enforcement action we took:

We issued a warning notice against the provider and the registered manager for the failure to maintain oversight of the safety and quality of the service.