HC-One Limited

Camberwell Green

Inspection report

54, Camberwell Green
London
SE5 7AS
Tel: 020 778 0026
Website: www.hc-one.co.uk

Date of inspection visit: 16 and 30 September 2015
Date of publication: 11/12/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Camberwell Green provides nursing care for up to 55 older people, some of whom have dementia. At the time of the inspection there were 40 people living there.

The home was last inspected on 26 February and 12 March 2015. At that inspection we found two areas which needed improvement. One concerned a damaged fire door and the other was about ineffective monitoring systems. The management systems remained a concern at this inspection and we are considering the action to take.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People did not receive safe care and treatment due to poor medicine management. People were given medicines at times when the GP had not prescribed them and one person received medicines which records stated they were allergic to. There were too few nursing staff to provide care safely for people. This led to medicines being administered late.

Summary of findings

People whose health conditions put them and others at risk of harm were not adequately supported through assessments and planning to manage the risks.

People who were at risk of dehydration did not always receive enough fluid to maintain their health and well-being.

Staff who were new to the service did not receive an adequate induction to provide care which reflected people's needs.

We saw examples of staff being caring towards people, but we also observed staff treating people with a lack of respect and regard for their dignity.

The manager and staff knew their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty of Safeguards.

Staff did not know people well enough to be able to provide a responsive service. There were opportunities for people to complain and make their views known to the manager and the provider. The registered manager investigated complaints and made improvements when appropriate.

Checks and audits were carried out but did not lead to improvements in the care people received. The CQC was not informed about events that the registered person is required to tell us about.

We identified breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to: safeguarding people from abuse and improper treatment, safe care and treatment, meeting nutritional and hydration needs, good governance and staffing. There was also a breach of a regulation of the Care Quality Commission (Registration) Regulations 2009. This related to the notification of incidents. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Summary of findings

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. People could not be sure they would receive their medicines as directed by the GP. People had been given medicines late in the morning or at other times which had not been specified by the GP. One person was given a medicine which the records stated he was allergic to.

The registered manager had not reported medicines errors to the safeguarding authority so they could be investigated under their procedures.

There were insufficient numbers of nurses available to meet people's needs safely.

People whose health conditions presented risks could have been harmed because risks were not assessed or responded to properly.

Is the service effective?

Inadequate

The service was not effective. People who were at risk of dehydration had their fluid intake monitored. Records did not show people received the amount of fluid appropriate for their needs.

New permanent and temporary staff did not receive an adequate induction to be able to provide personalised care.

The manager and staff knew their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty of Safeguards.

Staff completed the provider's mandatory training.

Is the service caring?

Requires improvement

The service was not always caring. Although there were examples of staff being caring to people this was not always the case. People were not always shown respect and regard for their dignity in written records and in the way they were treated.

The home had connections with a local hospice which supported the staff providing end of life care so they could learn about best practice.

Is the service responsive?

Requires improvement

The service was not responsive. Changes in the staff team meant people did not always receive a personalised service because temporary staff did know people well.

Care plans did not adequately describe people's individual needs that arose from their health conditions.

People and their relatives had opportunities to complain and give their views to the registered manager. The registered manager investigated complaints and made changes when appropriate.

Summary of findings

Is the service well-led?

The service was not well led. The registered manager had not informed CQC about incidents which they are required by regulation to tell us about.

Although the registered manager and provider made checks and audits of the way the care was provided, they had not led to improvements in the care people received.

Inadequate

Camberwell Green

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 16 and 30 September 2015 and was unannounced. Four inspectors and a pharmacist inspector carried out the inspection.

Before we visited the home, we spoke to the safeguarding and commissioning teams from the local authority. We also checked the information we held about the home. This included notifications we had received. A notification is information about important events, which the registered person is required to send us by law. We contacted other people involved with the home including a specialist nurse and an environmental health officer.

We made general observations when we were in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the information we held about the home including records of notifications sent to us. We spoke with 10 people who lived at the home and four relatives. We spoke with the registered manager and with eight other members of the staff team including nurses, care staff, catering and ancillary staff.

We looked at personal care and support records for eight people and medicines records for people throughout the building. We looked at other records relating to the management of the service, including policies and procedure documents and staff rotas. On the second day we visited, some records were unavailable because the manager was not present. We asked the registered manager to send us audit reports and we received them soon after our visit.

Inadequate

Is the service safe?

Our findings

People were at risk because of the poor medicines management, low staffing levels, failure to manage risks properly and because the provider had not always referred incidents to safeguarding authorities.

Staff did not follow the instructions of the prescribing GP when administering medicines and gave people more medicine than they had been prescribed. This put people at significant risk of harm. A medicine administration record (MAR) showed a person was prescribed a medicine to be given three times a day; we found that for 13 days this person had been given the medicine four times a day. On 30 September 2015 staff found this medicine was out of stock and none was available, this was not anticipated and the person missed one dose of the medicine. This showed that the systems for ensuring people had medicines available to take as prescribed were not effective and this put the person at risk. Another person had a medicine to be given three times a day. We found that the person received the medicine four times on two days. There was no record of consultation with the GP about this or instructions that it could be given at times that were not directed by the GP.

People were at risk from the misuse of medicines. One care record showed a person was prescribed a medicine to be taken on particular days of the week when they attended medical appointments. We saw entries on the person's MAR that they had been given the medicine two times which were not in line with the prescriber's instructions. There were no records of any consultation with the person, GP or other doctors before or after the person was given the medicine. The registered manager was unavailable when we found this issue. We spoke with a senior manager about this and explained our concern. They were not aware that this had happened. Handover notes for the time the medicine was given were not available so we could not check what information the registered manager was given about the matter. The nursing staff and manager in the home had not recognised this as matter which should have been reported to CQC and the safeguarding team.

People were not protected from being given medicines that were unsafe for them. We saw two entries on a person's care record stating that they were allergic to penicillin. We found they had been prescribed and nurses administered a medicine containing penicillin for five days. The person could have experienced serious harm because of this. There was no record of any contact with the prescribing GP or the pharmacist during this period. On the medicine administration record (MAR) the section where allergies should be recorded was not completed. The nursing staff or managers had not identified this error. The manager had contact with the GP after we identified the error and the GP stated they believed the person was not allergic to penicillin. Nevertheless there was no information to confirm that nurses were aware of this when they were administering penicillin.

Our findings showed that medicines were not managed in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People were given their medicines late each morning we visited. On 30 September 2015 a nurse began the medicines round at 10.35am on the second and third floors where 27 people lived. The medicines should have been given to people between 8am and 10am. Many of the people on these floors took several different medicines and had high levels of need. These factors meant the medicines round was lengthy. Nurses who were less familiar with people and their needs took longer to carry out the task. A nurse told us that even a permanent member of staff familiar with the medicine routine and people's needs could take up to 2.5 hours to administer people's medicines on these floors.

People's care needs were not always met because there were too few nursing staff available and there was a high use of agency nurses who were not familiar with people's needs. Within the last three months nursing staff levels had reduced from three nurses on duty every day to two nurses. On 30 September 2015 we found two nurses on duty providing the nursing care for the 40 people living at the service. On each of our visits there was only one permanent nurse on duty and the others were agency members of staff.

A senior manager told us on 30 September 2015 that they planned to increase nursing numbers from two to three from 21 September 2015. Records contradicted what we were told and showed that on three days of the week beginning 21 September and on 30 September there were only two nurses on duty.

Two people living at Camberwell Green told us their care was affected by the staffing levels. One person said when

Is the service safe?

they needed assistance they called for help using the call bell and said, "It takes a long time for them [staff] to come" and they said this was because "the carers are very few". Another person told us they used the call bell and staff responded but they felt it was "getting slower".

Four relatives we spoke with were concerned about the staffing levels. One told us they felt that there were too few staff available at the home to assist the people. They said they felt it was particularly short staffed in the afternoons and at weekends. They described the weekend staffing as "skeleton staff" explaining there were too few staff. They said the staffing was a particular concern as they felt that had an impact on the care people received. A second relative we spoke with agreed that staffing was not adequate to meet people's needs. They said there were "definitely not enough, they do need more staff." A third relative said the home was "lacking in staff" and said "staff numbers have dropped in the last couple of months".

We spoke with staff who felt that low staffing levels prevented them from "providing good care". They felt that "staffing is the main problem" and believed this had become worse from the time that one nurse was allocated to look after people on the second and third floors instead of two.

The Operations Director told us people's dependency needs were assessed individually but there was no overall assessment tool to determine staffing levels required to meet everyone's needs. She said that the numbers of people who lived at the service were taken into account and the manager's feedback about whether the staffing levels were appropriate was considered.

Our findings showed that there were not enough nursing staff to meet the needs of the people living at the home. This was a breach of Regulation 18 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Staff had assessed the risks to people's health and safety which came from their health conditions and wrote plans to manage them. The provider's policy was that these should be reviewed each month or more frequently in response to changes. People were not always adequately supported to manage conditions that could put them at risk of harm. A person was at risk of choking. Staff had assessed the risk as medium and this should have triggered certain actions including a referral to a specialist speech and language therapist for assistance with eating and a soft diet. Although a soft diet had been provided none of the other recommended actions were taken. Another risk assessment about choking was completed incorrectly and did not accurately assess the person's risk so it could be addressed.

We noted that one person had a fall in the morning before our visit on 16 September. Their risk assessment and care plan regarding mobility had been reviewed and their condition had been monitored to ensure there were no ill effects. However when we looked at a selection of risk assessments we saw they had not all been reviewed monthly as required by the provider's policy. For example a falls risk assessment of a person who had been assessed as being at high risk of falls had not been reviewed since 29 June 2015.

The provider had not sufficiently considered how to manage health conditions which put other people at risk of harm. One person was provided with individual care during the day to make sure people's safety was maintained. However there was no information to describe how risks were managed when the individual carer was not available. There was also no information on record to describe any signs that the person's health might be deteriorating and the action staff should take in response.

Staff had training in safeguarding procedures and they were aware of the action to take if they had concerns that people may be at risk of abuse. However staff and managers failed to recognise that the medicines errors and misuse were safeguarding matters that put people at risk. They should have made referrals to the safeguarding authority for the errors to be investigated with a view to keeping people safe.

This is a breach of Regulation 13(3) Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The provider acknowledged the food hygiene standards in the home had declined. The local authority awarded Camberwell Green a food hygiene rating of three stars (generally satisfactory) in early September 2015. This was a reduction in rating from their previous rating of four stars (good). The chef told us on 30 September 2015 they had conducted a 'deep clean' of the kitchen area in response to the food hygiene officer's findings.

Inadequate

Is the service effective?

Our findings

People were at risk of receiving too little to drink which can have a poor effect on their health and well-being. The records we viewed of fluid intake showed that people received less than the recommended amount for their needs. One person was recommended to have 2100mls of liquid a day, but on one day during the previous week they were recorded as having only 800mls and on four days they had received 1500mls or less.

In another record the recommended fluid intake total was not recorded which made it difficult for staff to monitor whether they were giving the person a suitable amount to drink. There was no reason noted for them to have a reduced fluid intake. Six daily records showed the person had drunk less than 1000 ml on four days and on one day their fluid intake as recorded as only 500ml. The nurse on duty confirmed that was inadequate for the person's needs. There was no recorded information to show how these issues were followed up.

A person was at risk of harm because action recommended by a health care professional had not been taken. A speech and language therapist had recommended that a person have thickened liquids because of the risk of choking. In the records of drinks given there was no reference to this need and reviews which had been undertaken since the recommendation was made did not result in changes to the care plan. We asked a senior member of staff about this after the inspection. She said that this recommendation, which was made in August 2015, had been missed and she said she would ensure that the thickener was prescribed for the person.

These issues were a breach of Regulation 14(1) Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

People were at risk of poor nutrition because the outcomes of assessments were not acted on. Staff assessed people using the Malnutrition Universal Screening Tool' (MUST) to check whether they were at nutritional risk. The outcome of the assessment was used to recommend what action should be taken. We found that the actions recommended were not consistently taken, for example on one person's chart it stated their weight should be monitored each week, but the records showed monthly monitoring took place. This meant staff could not respond quickly to changes in the person's condition. The weighing scales had been faulty for a period in June and July 2015 and this meant it had not been possible to carry out effective monitoring of people's weights.

People were not protected against eating foods which did not meet their healthcare needs.

Temporary chefs employed until the permanent post holder began the role were not knowledgeable about people's nutritional needs. We found on our first visit that catering staff were not aware of the people who required a high calorie diet to reduce their risk of malnutrition. An agency chef had worked at the home for a week and knew about some dietary needs but said he had not been informed about any people who required food suitable for diabetes or those who needed a high calorie diet. This showed that the induction of the temporary staff to the role was inadequate. The care staff, several of whom had worked at the home for a long time, were familiar with people's individual needs at mealtimes and could describe them to us. They ensured that the meals people received were suitable for them. On our second visit a permanent chef had been appointed and did know about these needs.

Staff gave people individual assistance with meals when this was required. We observed there was limited communication between staff and people at the meal. For example we did not hear staff describe the meal to people they were helping although we did hear staff encouraging people to eat. Staff were patient and helped people without rushing them.

New staff did not have an adequate induction to become familiar with people's needs. We spoke with a member of staff who had previously worked at the home and had returned after a three month period working elsewhere. Her first day of work was the day before our final visit. The only induction she had been given at that stage was a discussion with the deputy manager on her first day of employment. Full inductions were to be provided and staff training needs assessed by an HC-One training and development worker but this had not yet been provided. No new people moved to live permanently at the home since her previous employment. Nevertheless people's conditions had changed in that period. When we met the worker she was one of two nurses on duty and her induction had been minimal. We believed the induction was inadequate for her to be responsible for a shift the

Inadequate

Is the service effective?

following day as she had not had sufficient time to become aware of people's current needs and as the only permanent nurse on duty there was little support available from colleagues.

Staff received training in subjects that were mandatory for their roles. These included issues concerned with health and safety such as moving and handling, emergency procedures, fire safety, and infection control. Courses included care planning, equality and diversity and safeguarding people.

People had access to healthcare professionals when required. The GP visited the home each week and saw people who needed on going medical support. People saw the GP in response to their needs. A person who had complained of feeling unwell was seen at short notice and a course of medicine prescribed. Staff supported people to attend outpatient appointments when required.

The manager and staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff received training in the MCA and DoLS as part of their mandatory training. Applications to restrict some people's liberty had been made and the manager was awaiting the outcome of the assessments. There were suitable arrangements for ensuring applications for the reviews of DoLS were made. Mental capacity assessments had been conducted. If people did not have capacity to take part in important decisions, for example about a medical matters, best interests meetings were held in line with the requirements of the MCA.

Requires improvement

Is the service caring?

Our findings

People were not always shown respect and regard for their dignity. We saw an entry in care records that showed a disrespectful approach to the person they concerned. Staff had described a person as "very naughty". This showed a lack of compassion and failure to understand the person's medical condition and the reasons for their behaviour. It also showed a lack of regard for the person's dignity in the description as it is a term used to describe the behaviour of children rather than an ill adult.

Staff did not always treat people with respect. We observed staff assisting a person using a wheelchair, there was little communication with the person by the staff member. We saw the staff member take the person into the lift from where they could not see the lift without telling them it had arrived and they were going to enter it. The person was in good-humour but looked surprised about their unexpected movement.

We saw a person standing in the dining room while other people were brought to the room using wheelchairs. There was limited space and we observed a care worker say to the person "take a seat over there" and "go and sit". The care worker did not add "please" to their request and it sounded impolite and unpleasant. The person did not go to the chair and another care worker led the person to the chair and assisted them to sit down. This staff member showed more understanding of how to help people in a polite and respectful way.

People's records were not kept securely so that their personal information was kept confidential. Prescriptions were left on an unattended desk where visitors and other people could read them without permission. Similarly, people's files where confidential personal information was stored were left unattended on an armchair in the lounge where people and relatives could have access to them.

People told us they were looked after well, one person described staff as "lovely" and "so kind". Another person described staff as "fair enough" and said living in the home was "alright". A relative said "They [staff] are alright to me, they are always nice."

People benefit from staff receiving specialist training and support in end of life care. The home provided care for some people who were at the end of their lives. They had links with a local hospice. Two staff participated in a training programme provided by the hospice to increase staff knowledge and understanding about this area of care. A meeting was arranged with staff from the hospice in October to reflect on their recent experience of end of life care with the aim of giving them the opportunity to identify what had gone well in their care and what could be improved.

Requires improvement

Is the service responsive?

Our findings

People were cared for by staff who did not full knowledge of their needs. Relatives were not confident that staff had the knowledge of their family members' needs and the skills to meet them because of the changes to the staff team. Staff had left posts and there was a higher use of agency staff than was previously the case. A relative commented on the staff changes "one minute they [staff] are here and the next they are gone." They said they felt concerned about this because the care they provided was less personalised and responsive to individual needs.

Care plans did not adequately describe people's individual needs that arose from their health conditions. For example, a care assessment stated that a person had a visual impairment but did not give full details of how to provide care that ensured their needs were met. The plan described how to help the person to settle and how they liked to spend their day. However, there were no details of how assistance or communication with the person should consider their visual impairment. For example, there were no details of how to help them to identify who was talking to them, or how to assist them with meals by ensuring they knew what the meal included.

People were offered meals that reflected a range of cultures. A relative told us they would like their family member to receive food that was appropriate to their culture more frequently. A person told us they liked the food but would like it to be spicier. The manager anticipated that when the permanent chef began work they could develop the menu to provide a range of meals to meet people's tastes.

People benefitted from seeing visitors from community groups who were involved with the home. For example, members of a social group visited a person who shared their cultural background. Contact with members of their community was important to them. The group had put them in touch with people from their place of worship who visited them individually when they wished. A representative from an organisation for visually impaired people visited and provided the opportunity for individual conversations.

People's opportunities to take part in activities were limited because there had not been a permanent full time activity organiser in the home for three months. One staff member was working to arrange activities on a part time basis but there were too few staff to provide a meaningful; activity programme for all the people in the home. On the second day of our visit, she had arranged a Harvest Festival in the home that people and relatives attended. A large communal room was decorated in autumn colours and people came together for the activity. They looked cheerful as they sat together enjoying snacks and conversation.

People and family members had recorded information about their life histories but we did not see this used effectively, for example to plan activities which reflected individual interests.

People and relatives had opportunities to complain. They told us they felt comfortable approaching the manager to discuss concerns. A letter to a person who had complained showed the manager had considered the issues they had raised and apologised for the distress they had experienced. The manager told us that a complaint about the way people's clothes were laundered had led to improvements in the laundry service and they were glad that shortcomings had been brought to their attention.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February and March 2015, we found the service required improvement. The registered person had not protected people against the risk of inappropriate or unsafe care and treatment by means of regular assessment and monitoring the quality of the service provided.

We found at this visit that this remained the case.

People were not protected by quality monitoring, as the systems did not identify the issues which we found on our visits. Reports of monitoring visits addressed issues relevant to the quality of people's care and experience of like in the home. They had identified several areas where improvements were required but changes made did not have a significant impact. For example monitoring visits to the home by a senior manager reported concerns about staffing levels expressed by people living at the home, their relatives and staff and concluded that "staffing needs reviewing". The provider introduced an additional six-hour shift for a care worker but our findings were that this was insufficient to improve the care provided. We concluded the matter had not been adequately addressed and there remained a breach of Regulation 17(2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The notifications the provider told CQC about did not meet the requirements of the regulations. The manager had not told us about all incidents about which notifications must be made. These included a notification of an occasion when the police went to the home. We were not told about medicines errors, which could have put people at risk of harm. This is a breach of Regulation 18(1) (2) (f) of the Care Quality Commission (Registration) Regulations 2009.

In August 2015 the provider made a notification under Regulation 15 (1) (a) of the Care Quality Commission (Registration) Regulations 2009 which contained incorrect information. The notification informed us about changes to management arrangements, which they said, were due to take place from 28 August 2015. The registered manager told us that these changes were not correct. The provider did not make a formal notification to amend the information they had previously sent us.

The registered manager was familiar to people as she went around the building every day and talked with people, relatives and staff. People and relatives told us they knew the manager and had talked with her about their concerns. Staff felt the manager listened to them and they felt able to discuss concern with senior managers when they visited.

An electronic feedback system in the home's reception area gave people and visitors the chance to give ratings anonymously about their views of the home. People were asked to give their opinions of a range of matters including cleanliness and staff support. The feedback went to the provider who would report the results to the manager

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to investigate immediately upon becoming aware of evidence of abuse. Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Service users were not protected against the risks of inappropriate or unsafe care by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 17(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for service users, as they did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (g).

The enforcement action we took:
We are considering the action to take.

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 Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18(1)

The enforcement action we took:
We are considering the action to take.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person did not ensure the hydration needs of service users were met, as they did not ensure adequate hydration was provided to sustain good health. Regulation 14 (1) (4) (a).

The enforcement action we took:
We are considering the action to take.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The registered person had not notified CQC without delay of incidents specified in paragraph (2) which occur while services are being provided. The incidents CQC was not informed about are:

Any abuse or allegation of abuse in relation to a service user

Any incident which is reported to or investigated by the police

The enforcement action we took:
We are considering the action to take.