Cima Care Consortium Ltd

41 West Hill

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
41 West Hill is a residential care home providing regulated activity of personal care to up to 5 people. The service provides support to younger adults living with a learning disability and autistic people. At the time of our inspection there were 5 people using the service.

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

Right Support:
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible. Staff failed to ensure they did everything they could to avoid restraining people. The manager failed to review incidents of restraint and did not have oversight. This meant the manager missed opportunities to reduce or avoid the use of restraint, and to hold staff accountable where required. People continued to receive restrictive practice.

There were not always enough staff deployed for people to receive their commissioned support. Staff did not have the right skills and knowledge to support people effectively and ensure good outcomes.

Governance processes were not always effective in providing good quality care and support.

Right Care:
Care was not person-centred and did not promote people's dignity, privacy and human rights.

Staff and management did not always understand how to protect people from poor care and the risk of abuse.

Although there were good care plans in place, we were not assured these care plans were followed by staff and that people lived a meaningful and fulfilling life. People's interests, hobbies and daily living was not prioritised by management or staff. We found the service was staff and task-led, rather than person-centred and this impacted on people's dignity and human rights.

Right Culture:
The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives.

Poor management and lack of governance systems meant there were closed culture concerns at the service. People were not supported to live safely and free from unwarranted restrictions and people's rights were not always respected. The provider did not have oversight to ensure that management were assessing, monitoring and managing people's safety well. There was a lack of visible leadership and management, which meant people did not receive a service that was well-led. There were a lack of systems and processes to share relevant and honest information with relatives. Quality assurance systems were not in place to monitor and improve the quality and safety of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was good (published 13 December 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We undertook a focused inspection to review the key questions of safe, caring and well-led only. For those key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for 41 West Hill on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, person-centred care and good governance.

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

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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our safe findings below.	**Inadequate**

41 West Hill

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.

Inspection team
The inspection team consisted of 1 inspector and 1 Expert by Experience.
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
41 West Hill 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. 41 West Hill 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
The inspection was announced on 25 and 26 October 2023. We gave the service 20 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. We returned unannounced on the 6 November 2023 due to receiving concerns from the public.

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

During the inspection
We observed people and their interactions with staff and each other throughout the inspection visits. We spoke with 1 person, 3 relatives/representatives and 4 health and social care professionals to gain their views. We also spoke with 7 members of staff including the registered manager, deputy manager, 4 care staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records, this included 2 care plans, 5 medicine records, incident records, daily records and 3 staff files in relation to recruitment. We reviewed a range of records relating to the management and oversight of the service, staffing, risk assessments, health and safety records. After the inspection we continued to receive and review health and safety records, information relating to training, and a range of policies and procedures.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not always safeguarded from abuse and avoidable harm.
- Staff failed to recognise and report safeguarding incidents. For example, staff had noticed bruising and marks on people's skin and failed to recognise these as safeguarding incidents. These injuries had not been investigated to find the root cause. The lack of review meant the registered manager could not be confident people were not being exposed to ongoing harm either by accident or due to deliberate actions. This placed people at risk of abuse.
- We asked the provider to take action and assurances had been provided. However, when we returned on day 3 of the inspection, we found the provider had still failed to ensure potential safeguarding incidents were investigated to find the root cause. This put people at further risk of abuse.
- Staff had completed safeguarding training; however, this was not always effective as staff did not recognise or act on incidents of abuse. For example, we reviewed records where a person showed signs of distressed behaviour. Staff had taken the person's electronic device and told the person they would not receive it back until they had calmed down. Records lacked detail to show what positive strategies staff had used in line with their care plans before taking the device away. The meant people were at potential risk of psychological abuse.
- We could not be assured that people were protected from the risk of abuse or that lessons were learnt when things went wrong. Robust procedures were not in place to ensure concerns were identified and acted upon in a timely manner.

Systems and processes had not been established to protect people from abuse and improper treatment. This placed people at increased risk of potential harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

- Despite the above, a person living at the service told us they did feel safe. They told us, "Yes, I do feel safe, because they (management) keep an eye on staff."
- Since our inspection all staff including the management team have completed refresher training on safeguarding.

Assessing risk, safety monitoring and management

- The provider did not assess risks to ensure people were safe. Staff did not take action to mitigate any identified risks.
- When restraint had been used, records lacked detail. There was not always evidence to demonstrate it was necessary to use restraint, or that it was used for the minimum period of time, had a justifiable aim, and was used in a safe and proportionate way. We found a person had bruising to the skin from restraint being

used, but no investigation was completed to ensure safe practices had been followed. This meant people were at risk of harm by restrictive practice.
● After staff used restrictive practice such as physical or chemical restraint, the provider or registered manager had not completed post-incident reviews and had not considered what could be done to avoid the need for its use in similar circumstances. This meant staff failed to monitor and manage the use of restrictive practice which placed people at risk.
● Incidents had not always been investigated. Incidents and accidents should be investigated to identify any patterns or trends, with the aim of mitigating the risk of the incident or accident reoccurring. This meant people were at risk of harm through receiving unsafe care and treatment as a result of the reoccurrence of incidents.
● Environmental risks were poorly managed. For example, monitoring of water temperatures was completed, however staff failed to identify and take action when water exceeded safe temperatures. This increased the risk of scalding.
● Fire alarm testing had not been completed in line with fire regulations. Fire doors had been wedged open. We reported this as a concern on day 1 of our inspection. On day 3 of the inspection, we found the same risks. This placed people at risk of harm in an event of a fire.

Using medicines safely
● Medicines were not always managed safely.
● Staff did not always have clear guidance on 'as needed' 'PRN' medicines. This meant there was a risk people did not receive their medicines safely or inline with prescriber's instructions.
● A relative told us, "[Person] does take medication and they [the service] recently they sent [person] [medicine] home and it was over a year out of date. The home has asked me to drive over with Paracetamol for them because [person] has a headache and the one they keep for them was out of date."

Systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since our inspection the provider has told us they have fitted appropriate door guards that meet fire regulations, so doors can be open and will close in event of a fire.
● The provider has told us they have taken action by changing their processes and systems to ensure a more robust oversight, monitoring and investigations are completed when restraint is used.

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)

● Although the registered manager had completed mental capacity assessments the registered manager failed to ensure they were working within the principles of the MCA. We found people who required best interest decision did not always receive care in line with best practice guidance or the least restrictive options. ●

Appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment

● The service did not always have enough staff including for one-to-one and two-to-one support for people to take part in activities and visits, how and when they wanted.

● The rota demonstrated the right number of staff. However, staff were not appropriately deployed to ensure people received person-centred care. A person told us "Not really (enough staff). Say, I wanted to go out with the staff there isn't always enough staff that is on. It's happened a lot, I want to get my beard shaved off and I want it done at the hairdressers and no one can take me at the minute. I've been asking for a couple of days, and they (management) keep saying they haven't got enough staff."

● The registered manager told us they find it difficult to recruit staff who drive and this is why people can't go out in their own car or the company car as and when they want. They have given the option for people to use public transport, but people have declined.

● The training programme was not comprehensive to meet the needs of people and staff. For example, at the time of the inspection staff had not been trained in Makaton (a form of sign language) and people living at the service communicated using this method of communication. This placed people at potential risk of restrictive practices because people could not effectively communicate their needs to staff.

● Staff had completed training courses for learning disabilities, Autism and Pathological Avoidance (PDA). However, the provider did not complete competency checks following their training to ensure staff understood the training and put their learning in practice. Training attendance alone does not demonstrate staff understanding, or that staff would be adhering to and implementing the training.

● A relative told us, "Staff say [person] chose not to go out. But they have PDA, pathological demand avoidance, so they will always say no if staff ask if they want to go. If they asked, does [person] want to go to drama or for a walk, they would choose drama. Some staff do ask in this way, but I am sure that some staff do not and then they stays in their room."

● The provider operated safe recruitment processes.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

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

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The visitor arrangements at the service were in line with current government guidance. Visitors were allowed in the home throughout the inspection.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not supported to express their views and make decisions about their care. Throughout the inspection we observed staff not involving people in decision making about their care. Staff failed to give people choices in a way they would understand, to make decisions on what they would like to eat or what meaningful activities they could participate in.
- The provider failed to ensure people could express their views using their preferred method of communication. People living at the service required different communication methods. However, the provider failed to ensure these communication methods were explored and used. This meant people were unable to express their views and be involved in making decisions about their care, so were placed at risk of restrictive practice.
- We were told by relatives that when people were given choices, it would be to benefit the staff and people were not empowered to live a more fulfilled life. A relative told us, "[Person] has a mobility car. In the last couple of years, it has been very restricted to when [person] is allowed a driver. [Person] has attended dance and drama since a young age, which is about 45 minutes' drive away. [Person] generally went 3 times a week; [person] would go all day on the Wednesday, have lunch out and come back after the last session. But now, because of the diary, if [person] goes, they [staff] drive [person] in for the morning and then back again, then another drive both ways later. It is not such a nice day for [person]."
- People had not been given an opportunity to express their views or be involved in making decisions in relation to their activities and how they spent their time within their allocated one-to-one and two-to-one support hours. The provider failed to demonstrate a process and system showing how people are involved in the decision making of their weekly activity planners.
- A relative told us, "It's Halloween this week and they [staff] used to do something to celebrate, have a party or something. I phoned them [staff] to ask if [person] needed to bring a costume to wear and they [staff] said yes. If [person] had a visual planner like they should, it would have had a Halloween activity if it had been planned. But they [management] will just take a photo and show it like they have done something. They said they would celebrate Downs Awareness week, but they had the wrong month, and they wore odd socks but it wasn't about the welfare of the residents – just to show photos."
- Systems and processes were not in place to ensure best practice was followed when care plans were written in a service user's best interest. Relevant people, for example relatives, had not been involved in planning, reviewing and monitoring the care plans to ensure that service users' preferences were considered, and their needs were met. Relatives told us care plans had not been shared with them, "There is a care plan on site, but I am not involved in it."

Ensuring people are well treated and supported; respecting equality and diversity

● People were not always well supported and treated with respect by staff.

● We found records lacked detail of what staff did when people showed signs of distressed behaviour. Records did not demonstrate that positive language, engagement, and compassionate care were used to support people, before using restrictive practices such as restraint. This meant we were not assured people received kind and compassionate care, which people may have responded well to as stated in their care plans.

● People did not receive person-centred care. We found staff support was more task-focused and service-led. For example, three people living at 41 West Hill required two-to-one support when out in the community. Staff would decide when this support would be provided due to staffing levels. Staff told us, if two members of staff were already out in the community with a person and another person wanted to go out, they would need to wait for their 'turn'.

● Relatives raised concerns, comments included, "[Person] used to go out on their bike with staff but [person] hasn't for ages. I asked the manager about it, and [manager] said it was because staff bikes needed replacing. I chased again and they were waiting for black Friday to purchase them. They found a bike hire not too far away, it was a hire with track, so they went there and [person] loved the freedom of it. But now that's stopped, and they say it's because they are only doing activities local to West Hill because staff do not like to drive far."

● The provider failed to ensure people were treated with respect and their dignity was maintained when out in the community with staff. A relative told us, "If [person] goes bowling now with two staff. They [staff] just leave them to bowl and they sit down. They say the funding is not there for them. But part of their bowling is the competition and the interaction." The provider also failed to recognise the outcome for the person of equality, stimulation, fulfilment and enjoyment.

Respecting and promoting people's privacy, dignity and independence

● People's privacy, dignity and independence were not always respected and promoted.

● People were not always given the opportunity to try new experiences, develop new skills and gain independence. The management team told us all the people living at the service did not engage in activities they used to like. However, we found the management had not taken any action to find new interests for people. When relatives had raised ideas, relatives told us staff and management were not open to exploring new meaningful activities for people to participate.

● We found people were not given an opportunity to identify their goals and aspirations. This meant we were not assured the provider had a culture to support people to achieve greater confidence and independence to live a quality life. A relative told us, "I used to just walk in and get a friendly welcome and staff would ask if I'd like them to support my family member to make me a cup of tea. But now the manager and staff always seem to be unavailable in their room and my family member always seems to be in their room."

● People's privacy was not always respected. A relative told us, "Staff have to take the staff mobile to [person] because the land line doesn't work in [person] room. They [staff] stay with them, I can't always see them[staff] but [person] talks to them in the conversation sometimes. So, we don't have private calls."

● People's dignity was not always maintained. A relative told us, "They ruin [person] clothes so I now have to send their clothes in bagged up by the days. Then they come back to me, and I do all their washing. I like [person] to look nice but they either shrink them in the dryer or they disappear. I have to shave [person] often because they don't do that either."

The provider failed to ensure people were treated with respect, equally and care was person-centred and planned with people to ensure their preferences were met. Also, the provider had not ensured people's

privacy, dignity an independence was maintained. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and provider did not have the skills and knowledge to perform their roles and lacked understanding of risk management and regulatory requirements. For example, we found notifiable incidents had not been shared with CQC and/or Local Authority.
● The management and staff were not competent in ensuring information was accurate, properly analysed and reviewed by a registered manager who could understand its significance and take action to protect people from harm or potential abuse.
●For example, during and after day 1 and 2 of our inspection we fed back several concerns. These included poor record keeping by staff and lack of analysis, review and investigation of ABC (antecedent, behaviour, consequence) records and incidents by management. When we returned on day 3 of the inspection, we continued to find the same concerns. We were therefore not assured the registered manager understood the significant of this poor practice.
● Governance processes were not always effective in helping to review staff practice, keep people safe, protect people's rights and provide good quality care and support. The systems in place to ensure good governance of the care provided for people were not effective in identifying the risks found during this inspection.
● The provider did not understand acts of the duty of candour. Relatives raised concerns in relation to the management not always being open and honest with information regarding their loved ones. A relative told us, "There was an incident recently when they[staff] phoned me to say [person] had been restrained, a holding restraint. When [person] got home there were 8 marks on their body and yet no body mapping or incident report came home with them. They said it was still being written up. Then I chased again, and they said it had staff names on so they couldn't send it because of data protection. I got it months later via the social worker. But I always used to get a report if anything happened."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People received care and support from a service that had an embedded closed culture amongst the team working within the service. This had led to poor practices, a lack of openness with relatives and poor leadership within the service.
● A relative told us, "I think staff write down what they have done but they don't feed back to me. They

might show me a planner for [person] activities, but I would like to see exactly what [person] does, and I don't think it would match the planner."
● We were not assured the provider promoted a positive culture, that was person-centred, open, inclusive and empowered because staff failed to ensure people achieved good outcomes.
● Staff recorded when people experienced distress and agitation. However, the provider did not have a system to review and analyse the information, to learn and take action to reduce incidents or to determine better outcomes for people. This meant people were at risk of harm through receiving unsafe care and treatment as a result of the reoccurrence of an incident.
● People were at risk of harm as there was a lack of protection to prevent unnecessary restraint. The provider did not have systems and processes in place for monitoring when staff restrained people, in order for staff to learn from the use of restraint and consider how it could be reduced to achieve better outcomes for people.
● The provider failed to ensure there were robust systems and processes to ensure people's hobbies, interests, daily living needs were prioritised, or to ensure people could be inclusive and empowered to live a fulfilling and meaningful life.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider failed to have an effective quality monitoring system to inform them of areas of the service that required improvement.
● Concerns, risks and poor practice had been shared by relatives and the local authority. However, we found the same risks remained due to the lack of action taken by the provider to improve the quality of care.
● There were no systems or processes in place to actively seek the views of a wide range of people, this included people living at 41 West Hill, staff and relatives. Relative's comments were, "I haven't received a survey since before Covid." "We have no newsletters, no parent groups, no coffee mornings, or anything else they used to do. We are just not made to feel welcome." "I have no trust in them, lost all confidence. Definitely couldn't recommend it." The failure to seek feedback means the provider missed opportunities to gather feedback and use the information to identify concerns, risks and take action or make improvements to the service.
● The provider did not have systems and processes in place to improve care and promote a culture of continued learning.
● When relatives had made complaints or raised concerns, they felt this had a negative impact. Their comments were, "This all had a knock-on effect with our relationship with the directors. We were told we should not speak to them direct[ly] but we should only go through the manager. It became very different within the home."
● We found no action had been taken to embed a culture of learning lessons. For example, during their inspection in July 2021 and February 2023, the local authority had identified and highlighted 'poor incident recording and ineffective debriefs leading to lack of learning and understanding'. We found the same concerns during our inspection. This placed people at risk of continued poor practice.

The provider's systems and processes had failed to robustly assess, monitor and improve the quality and safety of the services and assess, monitor and reduce the risks relating to the health, safety and welfare of service users. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since our inspection the provider told us that they have employed an external consultancy company and increased senior management visits, to support with improving the oversight of the service and the quality of care people receive.

● The provider took action after our inspection and had provided us with an action plan on improving the service people received.
● Since our inspection the provider has told us they have made contact with relatives to seek their feedback, engage with them to improve care and to make the necessary improvements.

Working in partnership with others
● The local authority raised concerns that the service was not reporting a suitable number of incidents to the local safeguarding team. We found the provider was not reporting all required incidents, accidents or allegations to the local authority safeguarding team.
● Although we found concerns with the quality of service people were receiving, some professionals we spoke with felt the service was offering good care and the provider had worked in partnership with them.
● The provider had made health referrals in a timely manner. For example, if someone was not feeling well, they contacted the GP.

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 People were not being supported with personalised care, to have their communication needs met or to follow their social interests and hobbies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and the welfare of people using the service.

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 17 HSCA RA Regulations 2014 Good governance The service had a risk of closed culture and people were not being supported to achieve good outcomes. Audits were not in place to monitor the quality of the service and there were no plans in place to continually improve the service

The enforcement action we took:

Warning Notice