Kevindale Residential Care Home

Keegan's Court Residential Care Home

Inspection report

The Grange
Kerry Lane
Bishops Castle
Shropshire
SY9 5AU

Tel: 01588638898

Date of inspection visit:
19 February 2023
20 February 2023
27 February 2023

Date of publication:
04 October 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Keegan's Court Residential Care Home is a care home providing support with personal care to 3 people at the time of this inspection. The home can accommodate a maximum of 19 older people. Accommodation is provided in an adapted building providing 15 beds in the main building and two bungalows, each providing 2 beds.

People's experience of using this service and what we found
People were not safe from avoidable harm. Despite being aware of the lack of heating fuel, the provider had failed to purchase supplies resulting in the heating failing. This resulted in the physical temperature of the home reducing to an uncomfortable level increasing the risk of harm to people.

People were not protected from the risk of abuse or ill-treatment. The provider failed to act when concerns regarding staff members conduct were identified and passed to them. This put people at the risk of receiving inappropriate or potentially abusive behaviour.

People were not treated with dignity or respect. Confidential information was not secured and was accessible to those without authority. This information contained sensitive financial information and information regarding people's health and welfare. People's privacy could not be assured as communal toilet doors did not close or could not be locked.

The provider failed to ensure an effective fire management plan was in place, known, and followed by staff supporting people. This put people at the risk of harm in the event of an emergency. The provider failed to assess potential risks to people putting them at the risk of harm. The provider failed to ensure there were enough suitably qualified staff available to support people at all times.

People did not always receive their medicines safely or as prescribed. The provider failed to safely store medicines and failed to ensure medicines were administered in line with the guidance provided. The provider did not effectively analyse significant incidents to learn from them and to make changes to improve people's safety. People were not effectively protected from the risk of infection as the provider did not have adequate infection prevention and control measures in place. There was visible dirt in areas of the home and on fixtures. The provider had failed to update or implement the latest infection prevention and control guidance. The provider failed to complete checks on visitors to ensure they did not pose a risk to people.

The provider did not have effective quality monitoring procedures in place to drive improvements in the care they provided. The management team did not have clearly defined roles and responsibilities. The provider failed to have effective contingency plans in place regarding the restructuring of their business.

The provider followed safe recruitment practices.

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

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 inadequate (published 19 August 2022).

At that inspection there were breaches of regulation regarding safe care and treatment, safeguarding people from abuse, dignity and how the location was managed.

Why we inspected
The inspection was prompted by concerns about the management of the location and to follow up on breaches identified at the last inspection. A decision was made for us to inspect and examine those risks.

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

We have found evidence the provider needs to make improvements. Please see the safe, caring and well-led sections of this report.

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

We have identified breaches in relation to keeping people safe, safeguarding people from abuse, staffing and overall governance.

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
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

The provider has not made enough improvement and there is still a rating of inadequate for key questions safe and well led. We have commenced action in line with our enforcement procedures. This will mean we will continue with the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of 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 caring?

Inadequate

The service was not caring.

Details are in our well-Led findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Keegan's Court Residential Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
This inspection was completed by 1 inspector on days 1 and 3 and 3 inspectors on day 2.

Service and service type
Keegan's Court Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. In this instance the registered manager was also the provider. This means they are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

During the inspection
We spoke with 2 people who used the service about their experience of the care provided and we spent time in the communal area observing the support people received. We spoke with six staff members including care staff, head of operations, maintenance manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at 2 peoples care and support plans and several documents relating to the monitoring of the location and health and safety checks. In addition, we looked at three staff files.

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. 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.

●The physical environment was not safe for people. The provider had failed to purchase heating fuel allowing the heating systems throughout the home to fail. This resulted in the physical temperature dropping to a level which was uncomfortable for people. One person told us, "I have to keep my coat on as its cold." Another person took our hand and they were physically cold to the touch. The provider knowingly allowed the heating to fail for an estimated period of 72 hours until we insisted heating was restored as part of our inspection. This put people at the risk of harm from hyperthermia and other temperature related health conditions.

● The provider had failed to ensure staff knew people's individual needs in the event of an emergency. We spoke with one staff member about people's personal emergency evacuation plans (PEEPS). They had not read the plans and did not know what support people needed. They said, managers knew they hadn't read them, but no one had chased them up about it.

● The provider failed to keep a register of staff in the building or visitors. We saw multiple instances of staff entering the building and not accounting for their presence in the event of an emergency. One staff member told us, "We had a school party here earlier this week. I guess we didn't sign them in." This put people at the risk of harm as emergency services could not be provided with accurate information on how to assist people in the event of an emergency.

● The provider failed to assess the risk of harm from the use of portable heaters and radiators. Portable heaters were placed in dangerous positions including next to running water, in a doorway and in a cupboard. One staff member said, "I know we shouldn't use these heaters, so I hid it from you." The provider had failed to recognise the risks or take action to mitigate any harm to people. This put people at risk of electrocution and burns.

● The provider failed to ensure areas of the home were safe for people. Lighting had failed in the lift, in the kitchen and on the first floor. This created an increased risk of harm to people from trips and falls. One person told us, "I came down in the lift. It was scary as there were no lights, everything just went dark until the doors opened again."

● The kitchen area was unlocked and accessible to people. The lighting had failed, and the provider had

stored a large step ladder in the upright position. This put people at risk of trips and falls and crushing from the unsafe storage of equipment.
● The provider failed to safely store hazardous materials. We saw substances hazardous to health (CoSHH products) throughout the building. This included nail varnishes, toiletries and cleaning chemicals identified as corrosive and hazardous which were openly accessible to people. Flammable liquids were stored in a cupboard under the main staircase long side shredded paper. These issues put people at the risk of harm from accidental or intentional ingestion and from the increased risk of injury from fire.
●People were at risk as the provider failed to ensure the physical environment was safe for people. There were multiple locations throughout the home where the radiator valves were missing exposing a sharp point. This put people at the risk of harm from penetrative injury.
● The main lounge window was cracked compromising its structural integrity putting people at the risk of harm from laceration. Outside the first-floor fire exit a large ladder was stored in the upright position and unsecured, there was a trailing hose pipe along with other items stored in this area. People were mobile and could access this area. This put people at the increased risk of harm as the provider failed to ensure this area was safe for people to access.
● The provider failed to ensure a vehicle used by the business met legal requirements.

Using medicines safely
● Medicines were not safely stored. The medication room was unlocked, and the medication trolley was not secured to a fixed point. This was not in accordance with safe storage guidance.
● People did not receive their medicines safely or as prescribed. One person received their prescribed medicines through medicated patches. The provider failed to identify these patches were not being applied at the correct intervals. The nominated individual told us, "I don't know why this has happened." The provider failed to identify the records of these patches on the body did not match where the actual patch had been applied. This put people at the risk of skin breakdown as it hampered effective site rotation.
● Medicines which were sensitive to temperatures were not safely stored. Eye drops were kept in the trolley and not the fridge and not within the safe temperature range. This put people at the risk of harm from receiving ineffective medicines.
● People did not always receive their medicines as prescribed. One person was prescribed medicated eye drops 6 times a day from a disposable single use vile. The provider incorrectly transcribed these instructions on to the medication record and the person only received their medication 4 times per day. This put people at the risk of harm from not receiving their medicines as prescribed. The single use disposable vile was used for multiple doses and not discarded in accordance with instructions. As this medicine did not contain any preservatives this put people at the risk of harm from infection.

Preventing and controlling infection
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. We saw tables were visibly dirty to the eye, unknown substances on high frequency touch points including light switches and radiators, and sticky substances on door frames. In addition, we saw damaged toilet surrounds, broken radiator surrounds and exposed wood on furniture and toilet fixtures. The provider did not have designated domestic staff to support effective infection prevention and control practices putting people at the risk of harm from communicable illnesses.
● We were not assured the provider's infection prevention and control policy was up to date. They had not implemented the latest guidance. For example, none of the inspection team were asked about any risks they presented on entering the building. The nominated individual told us they always ask for a visitor's proof of vaccination and if they didn't have a COVID-19 vaccination they would stop them visiting. This was not in accordance with guidance. A staff member told us they had not been told what to ask or when they needed to wear face masks.

● We were not assured the provider could admit people safely to the service as they had not updated their police with the latest guidance.

Visiting in care homes
● The provider was not supporting visits in line with the Governments guidance. The nominated individual failed to access and implement the latest guidance on visiting. They failed to communicate changes to staff members to ensure visitors were consistently permitted into the home to visit people.

Learning lessons when things go wrong
● The provider did not have effective systems in place to learn when things went wrong. When incidents or concern were known the provider failed to act on them. Concerns had been previously raised with the provider regarding the conduct of one of their staff members. They informed the CQC appropriate action had been taken with this staff member but could not evidence this. We later confirmed with the head of operations, and the staff member, no action had been taken regarding their behaviour. The provider failed to act to learn from incidents. This put people at the risk of repeated staff misconduct.
● Although the head of operations told us they had systems in place to identify and address accidents, incidents and near misses, they stated no incidents had happened since our last inspection. However, they failed to identify the issues of concern at this inspection which should have led to investigation and action to minimise the risk of occurring in the future.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. These issues constitute a continued breach of Regulation 12 (Safe Care and Treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection systems were not robust enough to safeguard people from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) 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 13.

● People were not protected from the risk of abuse and ill treatment. During our inspection we raised 5 separate safeguarding alerts with the local authority. These issues had not been identified by staff or the management team and as such had failed to act to safeguard people from suspected abuse.
● When concerns were known the provider failed to make alerts to the appropriate agencies to safeguard people. We identified an incident where a staff member acted directly against a person's known wishes and performed an invasive intervention. The provider knew about this incident yet failed to identify this as an issue and failed to take any corrective action with the staff member concerned. This put people at risk of abuse and ill-treatment.
● People's personal property was not accounted for or accurately recorded. The provider had taken responsibility for a person's property which was stored in the providers safe. This item was not recorded anywhere in the persons inventory or elsewhere in the building. Details of peoples personal banking were left in the reception area along with personal banking identification numbers which should remain confidential. This area was accessible to people and visitors. These issues put people at the risk of financial and material abuse.

Systems were not robust enough to safeguard people from abuse and improper treatment. This placed people at risk of harm. These issues constitute a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When these issues were identified we contacted Shropshire Fire and Rescue and Shropshire's Local Authority adult safeguarding team to raise our concerns in order to keep people safe.

Staffing and recruitment

● The provider failed to ensure there was adequate staff available at all times to meet people's needs. Owing to changes in the providers situation a significant amount of staff had left or been removed from their employment. During the inspection the head of operations and maintenance manager were made redundant with immediate effect. The provider failed to make contingency arrangements for the continued provision of services following the removal of these employees.

● The provider introduced a new role of sleep-in staff but failed to provide guidelines or instructions supporting the staff in this role. For example, the providers fire safety risk assessment specified 2 staff members to be available at all time to assist in the event of an emergency. We noted the sleep-in staff member had returned to their home address and had to be phoned to return to the building on our arrival. This meant there was insufficient staff available to support people at all times.

● Staff were expected to work long hours with little provision for breaks or time in-between shifts. The nominated individual provided a revised staffing rota identifying 2 staff who were expected to provide all daytime care for a period of 7 days without designated breaks and in multiple instances the sleep-in provision as well. One staff member was on the rota for working 8 consecutive 12 hour shifts including 5 sleep ins and 1 waking night. The provider failed to identify the potential risk of fatigue and poor practice resulting from such demanding hours. The nominated individual told us they had approached their new business partner for staff. However, they failed to act in the intervening times whilst awaiting the appointment of new staff.

● The provider failed to ensure those they employed to complete specific tasks were trained and competent to do so. The maintenance manager told us they had not received any training in risk identification or mitigation. However, they were expected to complete all environmental risk assessment without any assessment of competence. This put people at the risk of harm as the provider could not evidence the assessments were completed by a competent person.

● Staff completed tasks they were not trained to do. One staff member was up a ladder, at night, in the kitchen without any lighting attempting to correct an electrical issue they were not trained or competent in. The nominated individual told us, "I know this should not be done and we will get an electrician in to mend it."

The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the requirement of their registration. These issues constitute a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with others.

● We were assured the provider was meeting shielding and social distancing rules.

● We were assured the provider was accessing testing for people using the service and staff.

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]

● People were engaged in decisions about their care and support and staff supported people in the least restrictive way possible.
● We found the service was working within the principles of the MCA. At the time of the inspection all those residing at Keegans Court had the capacity to make decisions and told us they were involved in making decisions about their care.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

At our last inspection people were not treated with dignity or respect. This was a breach of Regulation 10 (Dignity and respect) 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 10.

● People were not always treated with dignity and respect. People had access to 2 communal toilets on the ground floor. One toilet had no lock and a hole in the door where the door furniture had been removed. We asked a staff member about this. They said, "Oh, visitors and staff don't use that toilet as you can't lock it." They confirmed people were expected to use this toilet and did not understand the implications of their compromised dignity. The other toilet's door was difficult to shut, and force had to be applied to close the door. Again, we asked a staff member about it and they told us, "Oh we don't usually close that door as it's a bit stiff." Again, there was little understanding from staff about the importance of maintaining people's dignity.
● People did not have their confidential information secured safely. Financial records including confidential banking details were left in the main reception area which was accessible to people and visitors.
● Peoples private information regarding their personal care needs and medication was also accessible to those without authority.

People were not treated with dignity or respect. These issues constitute a continued breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's protected characteristics under the Equalities Act 2010 were known by staff members. These included gender, sexuality, disability, ethnic origin etc.

Supporting people to express their views and be involved in making decisions about their care
● Despite our findings people felt they were generally well cared for and looked after. One person said, "I get on well with everyone and have a good relationship with the staff.

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 the last inspection this key question was rated inadequate. At this inspection this key question has remained 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. Continuous learning and improving care.

At our last inspection assessments were not robust enough to demonstrate their quality monitoring was effective. These issues were a breach of Regulation 17 (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● This location was first registered with the CQC in November 2017. We first inspected in January 2019. Since the time the location has been registered, they have been inspected on 8 occasions where we have provided them with a rating. They have consistently failed to reach an overall rating of good at any inspection. Out of the 8 inspections the provider has been in breach of regulation on 7 occasions.
● At our last rated inspection, published August 2022, we identified breaches of regulations. This was in relation to the safe provision of care, failure to safeguard people from abuse, maintaining dignity and governance. The provider remains in breach of these regulations with the addition of a breach regarding staffing.
● Since our last inspection the registered manager has resigned their role. Mid-way through this inspection the head of operations and maintenance manager were made redundant with immediate effect by the provider. The provider did not have a contingency plan in place to address the changes in management within Keegans Court. People and staff did not know who was responsible for managing the service. One staff member said, "I think [previous registered manager's name] is still in overall charge. One person stated, "[Head of operations name] is the manager here." The provider failed to identify who was responsible for the running of the service and individual roles and tasks were unclear.
● The provider did not have a service improvement plan to address the shortfalls in the service. We asked the nominated individual on multiple occasions how they were intending on improving peoples' experience of care and the only response we received was, "Please give us a chance." There was no evidence they were able to identify or understand the improvements needed or were able to make the changes to improve people's experience of the care they provided.
● The nominated individual told us they had employed the services of a consultancy agency who had visited. However, they had not received any feedback and therefore had not made any changes yet.
● The provider failed to act when risks were identified to them. For example, the provider was informed

heating fuel was running out but made the conscious decision not to purchase fuel. Instances of poor staff conduct had been raised with the provider and they failed to act to address the concerns with the staff member.

● The provider failed to notify the CQC of significant events within the service. A staff member informed us about an incident within the grounds of Keegans Court where staff were in dispute with the provider and police were called. We confirmed this with the nominated individual who then made the appropriate notification, albeit after a significant delay.

● The provider failed to have effective quality monitoring systems. For example, their checks failed to identify missing risk assessments for the use of portable appliances. Checks failed to ensure the physical environment was safe for people or repairs were completed in a timely way by a suitably qualified person.

● Checks failed to ensure people received their medicines as prescribed. They failed to ensure medicines were safely and securely stored or complete checks to correct errors in administration and recording of medicines.

● Prior to their redundancy, the operations manager told us they did regular walk around checks of the building. However, these checks failed to identify the multiple concerns we found including the temporary use of insulation foam on radiator pipes, missing radiator valves, poor cleaning practices, a broken window, and poor lighting.

● They failed to ensure people's dignity was maintained and that people had access to private and secure toilets. They failed to ensure records which were private and confidential were secured. They failed to identify and address unsafe staff practice.

● The providers own quality monitoring processes were inadequate in identifying or correcting issues with the support they provided.

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 nominated individual was not aware of their responsibilities under the duty of candour. The duty of candour is a regulation which all providers must adhere to. Under the duty of candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

● The nominated individual had failed to identify significant incidents which required investigation to identify what had gone wrong and could be done different. As a result, they failed to feedback to the person, relatives or other concerned persons. They did not have systems in place to identify learning or what could be done differently.

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

● The head of operations told us they had not engaged people in an attempt to gather their thoughts and feelings about the service they received. One person told us they didn't really know what was happening with the home and all they had heard were "Just whispers". This meant people were not given information in a way which they could make an informed decision about where they lived.

● We asked the nominated individual how they engaged people to support their understanding about the challenges they faced and the restructuring. They were not able to outline for us how they engaged people, meaning they could not demonstrate an open or inclusive culture.

Managerial oversite and environmental assessments were not robust enough to demonstrate their quality monitoring was effective. These issues constitute a continued breach of Regulation 17 (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The management team had established and maintained links with the local communities within which people lived. For example, GP practices and district nurses. The provider worked with social workers to support some people's move from Keegans Court to alternative accommodation.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure peoples dignity was respected at all times.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were safe.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.

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 failed to identify or investigate suspected incidents of abuse.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have effective systems in place to identify and drive good care.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient staff available to support people at all times.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.