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Grafton House Residential Home

Inspection report

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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**

Summary of findings

Overall summary

About the service
Grafton House Residential Home is a care home providing accommodation and personal care for up to 24 older people, some of whom may be living with dementia. At the time of our inspection 12 people lived at the service.

People's experience of using this service
People were not safe. Risks to people were not appropriately managed or recorded. Lessons were not learned when things went wrong.

People were not protected from abuse; not all staff had received training and did not know how to recognise or report abuse. Concerns identified by health professionals in relation to standards of care and moving and handling practices were reported to the local safeguarding team.

There were insufficient numbers of suitably qualified staff on duty and staff were unfamiliar with people's care and support needs. Staff had not been provided with sufficient training or induction to their role.

Maintenance issues had not been addressed in a timely way. Appropriate standards of hygiene had not been maintained in all areas. Effective infection prevention and control (IPC) measures were not always followed by staff and management. Risks in relation to transmission of infections had not been fully considered and managed. This had placed people at risk of harm.

People did not always receive person-centred care and care records did not fully reflect their needs. There was a lack of meaningful activities for people.

The principles of the Mental Capacity Act were not always followed. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive ways possible and in their best interests; the policies and systems in the service did not support this practice.

People's nutritional needs were not always met, and mealtimes were disorganised. Although staff worked closely with a range of health and social care professionals, there had been delays in making referrals for health care assessments when some people's needs changed.

Staff were recruited safely, and medicines were managed safely. People and relatives said they liked the staff and described them as kind and caring. However, there were times when some people's dignity was compromised.

The service was not well-led. The provider had failed to retain a competent manager. Leadership was poor and ineffective; staff lacked direction and support and were left to their own devices. Many of the staff who knew people well had left; inexperienced staff had been appointed to senior roles and the high use of new

staff, who were not familiar with people's needs, had impacted negatively on the service. The provider's quality assurance systems were not effective in identifying and addressing issues. The service has a history of not sustaining improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 26 February 2021).

At this inspection enough improvement had not been made and the provider was in breach of multiple regulations and there were significant concerns. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

Why we inspected
The inspection was prompted in part due whistleblowing concerns and the decision taken by North Lincolnshire Council Adult Safeguarding Team to open a whole service enquiry due to the level of concerns raised in relation to IPC, staffing, the quality of care and management of the service. As a result, we undertook a comprehensive inspection to review the key questions of safe, effective, caring, responsive and well-led.

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

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, safe care, safeguarding, consent, dignity and respect, nutrition, the environment, staffing numbers and training and good 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.

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

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

Grafton House Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 carried out by an inspection manager and two inspectors.

Service and service type
Grafton House Residential 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.

The registered manager had resigned in April 2021. A new manager had been appointed in April 2021. It is a legal requirement to have a registered manager. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced. We told the manager we would be returning on the second, third and fourth days.

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, professionals who work with the service and attended safeguarding strategy meetings. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to 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 used all information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with the provider and 15 members of staff including; the manager, quality assurance lead, six care staff, two senior care assistants, two housekeepers, the cook, the maintenance person and the activity coordinator.

We also spoke with eight health and social care professionals who visited the service.

We reviewed multiple people's care files, daily records of care and medication records. We also reviewed three staff personnel files. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We conducted a walk around of the service and spent time observing staffs' interactions with people as well as staffs' infection prevention and control practice.

After the inspection
We spoke with a health care professional.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The further improvements needed in risk management that we identified at the last inspection, had not been put in place. Risks to people were not properly assessed or managed safely. Risk assessments were not always updated following incidents or a change in people's needs.
- Staff did not always follow safe practices when moving and handling people and did not always use the equipment people required.
- People's risks of sustaining skin damage were poorly managed. Two people sat for hours without the pressure cushions they required, and some people were left to sit in their wheelchairs for long periods of time. One person was provided with a new pressure relieving mattress, but there was a delay of 24 hours before it was put in place. People did not receive effective and timely support with repositioning, which placed them at risk of skin damage.
- People who were at risk of choking did not always receive the type of diet or support they required.
- Fire safety was not robust. Not all staff had completed fire safety training, fire drills or evacuation training. This meant they may not know how to support people safely in an emergency.
- The safety certificate for the passenger lift had expired in April 2021 which meant the safety of the five people who resided on the first floor was not protected when using this equipment.

People were placed at risk of harm due to poor risk management. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People were placed at significant risk of contracting infections due to poor practices in place.
- Government guidance in relation to COVID-19 management had not been followed. Staff did not always use personal, protective equipment (PPE) effectively and safely. PPE was not stored safely to minimise the risk of it becoming contaminated before staff used it.
- People were not supported to isolate when discharged from hospital to reduce the risk of cross contamination.
- Safe systems to ensure whole home testing for people and staff were not in place. Testing frequencies were not consistent. The system to check results was not robust. One person's positive results had been received the evening before the inspection, yet staff were not informed until 21 hours later.
- There was a risk staff would spread infections. Staff did not consistently follow good hand hygiene practices when supporting people and their decontamination of shared equipment was not robust.
- Not all areas of the service were clean. Some flooring, furniture and equipment was dirty and there were

malodours in three rooms.

Not ensuring good infection prevention and control systems placed people at risk of harm. This was a breach or Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People's basic care and support needs were not being met due to insufficient staffing numbers. The routines were chaotic, and staff told us they often had to rush people with their personal care.
● The provider calculated how many staff they needed via a dependency tool. But they did not consider specifics such as the layout of the building, asking staff, people and relatives for feedback about staffing levels or use observations of care delivery as part of their assessment.
● Staff were overstretched and regularly went without breaks. They all told us the numbers of staff on shift was insufficient.
● Staff were not always aware of people's needs and how to meet these. Newly recruited staff told us they had not had training, not read people's care plans and been given limited information about people's needs and risks.
● People in communal areas were often left unattended and we had to request support from staff on multiple occasions when people became anxious and distressed.
● There had been a high turnover of staff since May 2021, eight staff had left and there was an ongoing recruitment programme. There had been regular shortfalls of staff on shifts and agency staff had not been used when care staff could not cover the vacancies. On the third day of the inspection, North Lincolnshire Council took the decision to provide additional care staff on each shift to support the safe delivery of care.

The lack of sufficient, competent staff meant people were not safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment procedures were mostly followed. A newly recruited member of staffs file contained only one reference which was being followed up. Interview records were not always completed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not safeguarded from the risk of abuse.
● Some staff on duty did not have appropriate training and did not know the process to follow if they had any safeguarding concerns.
● Visiting professionals had raised safeguarding concerns in relation to the care people were receiving. This included professionals observing staff using inappropriate moving and handling techniques.
● The provider had not acted accordingly to learn lessons when things had gone wrong. Following incidents in March 2021 when a person left the building and regularly accessed other people's rooms, although the provider had contacted the person's GP they also took the decision to put additional locks on people's doors and a ground floor fire door. The risk the locks could restrain people or compromise safe evacuation in an emergency had not been considered, and these were only removed when the local safeguarding team raised serious concerns.

The provider failed to establish and operate systems and processes to ensure people were protected from abuse. 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.

Using medicines safely

● Medicines were stored, recorded and administered appropriately. We observed a member of staff giving people their medicines in a safe way.
● The recording and use of protocols for 'as needed' medicines were inconsistent. Protocols were not always in place and some protocols needed more information to guide staff, for example the dosage of medicine to be administered.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
- New staff did not receive an appropriate induction to their role and were unfamiliar with systems and processes in place, such as action to take in the event of a fire.
- Staff had not been provided with sufficient training. One staff member was providing direct care support on their first shift and told us, "I have not received any training at all since I started working here."
- Not all staff with responsibility for administering medicines had received medicines training.
- Due to the lack of induction and training provided, we observed poor staff practice in relation to moving & handling, IPC and food and fluid management.
- The staff supervision programme had not been maintained. Staff told us they did not receive enough support and guidance to carry out their duties and meet people's needs safely.

Failure to ensure a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 Act 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The service was not following the principles of the MCA. There was a lack of records to show mental capacity assessments and best interest meeting records had been completed for some people who lacked capacity to consent to their care.
- Restrictions were in place, for example the use of bedrails and sensor mats. People's capacity to make

these decisions was not always completed and the decision for the restrictions had not been discussed and recorded as in their best interest and as the least restrictive option for people.
● For those people who lacked capacity there were no records to show consent had been sought for their COVID-19 vaccinations. There were no consent records in place when people had moved bedrooms.
● Some people had deprivation of liberty authorisations in place. There had been recent delays in the provision of information requested by the local authority regarding review and renewal.

Failure to ensure consent to care in line with the law was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Maintenance work to the environment had not been sustained. There were regular issues with the hot water supply throughout the building, due to problems with the boiler, which had not been addressed.
● Timely action to address fire safety deficiencies in relation to the maintenance of fire doors and segregation of the loft space had not been completed.
● Damaged paintwork to a bath hoist, tiling in the kitchen and flooring in the laundry required repair or replacement to ensure effective standards of hygiene could be maintained.
● Adequate moving and handling equipment to safely meet people's needs was not in place. Therapy teams provided additional slings for three people so each person who used the portable hoist could have their own. They also provided slide sheet equipment to support staff to reposition people safely.

Failure to ensure the premises were properly maintained was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Systems were not in place to ensure people's needs were always assessed and their preferences fully understood. This meant people were at risk of receiving inappropriate care and support.
● Professionals raised concerns about the care and support being provided to people.
● Staff did not always seek support from health care services to ensure effective and timely assessment.
● A team of community nursing staff and therapists had completed assessments of each person's current needs and identified nine people's needs had changed and they required more support and in some cases equipment to maintain their health and welfare and keep them safe.

Failure to assess people's needs effectively was a breach of Regulation 9 (Person- centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not given a choice of meals. Menus were not being followed. People living with dementia were given food their records showed they disliked.
● People were not always provided with a suitable diet to meet their needs and ensure their safety. Some care staff and the cook lacked knowledge and understanding of people's dietary needs.
● Mealtimes were chaotic and disorganised, the support people required with food and drinks was not always provided, which placed them at increased risk of malnutrition and dehydration.
● Food and fluid charts were not completed correctly and were not monitored by senior staff to make sure people were having enough to eat and drink and that one person's strict fluid restriction was safely supported.

Failure to provide adequate support with food and drink to meet people's health and preferences was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last comprehensive inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People's privacy and dignity was not always promoted or maintained.
- People looked unkempt because staff had not supported their personal care needs. People were not supported to shave, their hair was not brushed, some people wore stained clothing and some people had no socks, slippers or shoes on.
- Some people did not have enough toiletries or items of clothing such as socks and underwear. People did not always have their own clothing returned to them.
- Staffing levels impacted on people's dignity as interactions between people and staff were limited and there was a focus on completing tasks. A member of staff told us, "We just don't have time to spend with people; we are always rushing, and things get missed."
- Staff were not protecting people's dignity when using the hoist for transfers. We observed staff experienced problems with a person's transfer and the person's clothing was disturbed in an undignified manner in a public area.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care
- People were not consistently well-treated and supported by staff.
- Some staff were kind and compassionate with people and we saw positive relationships either had or were being developed. A staff member reassured one person who was upset and spent time sitting with them comforting them.
- Not all staff understood people's needs or how to communicate effectively. One person was visibly anxious and shouted out frequently. Staff did not respond and looked on without any attempt to engage the person. Another person was asking repeatedly for a cup of tea and becoming upset, yet several staff walked past and ignored them. The person received their tea when one of the inspection team requested this for them.
- Relatives said the staff were kind and caring and there was a 'nice family atmosphere' at the home. People told us they liked the staff describing them as 'lovely girls' and 'a kind bunch,' but they also talked about having to wait long periods of time for care support, staff not having any time to spend with them and feeling lonely.
- People's views about the service had not been sought recently and there was limited evidence to show people were involved in decisions about their care.

People were not always treated with compassion and their privacy and dignity was not respected. This was

a breach of Regulation 10 (Dignity and respect) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last comprehensive inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People did not always receive person-centred care which met their individual needs.
- Professionals told us some people had not received enough support with personal care, toileting and dressing to ensure they were clean, warm and comfortable.
- People's needs had not been effectively assessed or reviewed. Their care records were not always up to date or reflected their individual care needs or preferences.
- New staff told us they did not have time to read people's care plans and knew little about people's life histories, important events and people who were important to them.
- Basic end of life care plans were in place but lacked sufficient detail to enable staff to offer appropriate support in line with people's wishes and preferences.
- Given the lack of stimulation and time given to people, we were not confident this part of people's lives was being managed in a thoughtful and caring way.

Staff did not have the time or information to meet people's needs in line with their preferences. This was a breach of Regulation 9 (Person-centred care)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was limited social stimulation for people in order to prevent boredom and isolation.
- A new activity coordinator started work during the inspection and supported a group of people with planting flowers and hand care. There was no structured programme of activities or records available to show what recreation had been provided since the previous coordinator had left in April 2021.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were considered as part of their care plans.
- The manager understood their responsibility to comply with the AIS and could provide information about the service in different formats to meet people's diverse needs.

Improving care quality in response to complaints or concerns

● A complaints policy and procedure was in place. We asked the manager for the complaints log and they confirmed they had not received any complaints.
● Relatives knew how to make a complaint and told us the manager was approachable and dealt with issues appropriately.

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 as requires improvement. At this inspection this key question has deteriorated 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; Continuous learning and improving care

- Since ratings were introduced, we have only rated this service as 'inadequate' or one that 'requires improvement.' The service has a history of breaching regulations and failing to sustain improvement.
- At the last inspection, we made a recommendation to strengthen and update the governance systems. Improvements had not been made. Systems and processes did not sustain improvement.
- Shortfalls and concerns had not been identified or addressed by the provider's quality assurance system. Nine breaches of regulation were identified during the inspection.
- The provider had failed to retain a competent manager at the service. There had been changes in management since the last inspection. An acting manager was in post who informed the provider of their intention to leave the service part way through the inspection.
- The service was not well-led. The provider and manager failed to provide effective leadership, direction and support to the staff team. Communication about people's needs and risks and how to manage these was inconsistent and staff were left to fend for themselves.
- An effective system to learn from accidents and incidents and prevent any reoccurrence and improve people's care was not in place.

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; Working in partnership with others

- People did not always receive person centred care due to the poor staffing levels. Staff were observed to be kind and caring. However, they were under increased pressure due to the failings identified in this report and therefore unable to deliver the care they wanted to.
- There was a clear lack of effective oversight from the provider which impacted on the outcomes for people. A person-centred service was not provided. Thorough checks on individuals' care and quality of their daily experiences were not being completed, to satisfy themselves if the service was good.
- Staff were not supported within their roles and staff morale was low. They had not been provided with sufficient training to ensure they had the skills and knowledge they needed to enable them to provide person-centred care and support.
- People, staff and people's relatives were not being asked in a meaningful way about their views of individuals care.
- Guidance from other professionals in relation to COVID-19 had not been followed, which put people at increased risk of harm.

● There were times the manager and provider were not accessing support and advice from other professionals in relation to people's needs, when they should have done.

There was ineffective leadership at the service. Processes and effective systems were not in place to test the quality of the service and respond to failures and concerns. There was a lack of insight about the standard of care provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider listened to our concerns and feedback of the service. On the third day of inspection they informed us and North Lincolnshire Council of their decision to close the service. Following the inspection, they informed relatives, people and staff of their decision and worked closely with the local authority to support people to move to new placements.

● The provider had appropriately notified agencies of all incidents.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure people's care and treatment was assessed, planned, recorded and delivered to meet their needs and preferences.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure people's privacy and dignity were maintained.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not worked within the Mental Capacity Act 2005, when people lacked the capacity to make their own decisions.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure people's care and treatment was provided in a safe way. Risks to people were not appropriately

identified, reviewed and mitigated.

Infection prevention and control was not managed safely or appropriately.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

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 registered provider had failed to ensure people were protected from abuse and neglect.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to ensure people's nutritional needs were met.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure the premises were well-maintained.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure consistent and effective leadership and failed to embed robust governance systems.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation

for persons who require personal or nursing care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to provide sufficient numbers of staff with appropriate training and professional development as necessary to enable staff to carry out the duties they were employed to perform.

The enforcement action we took:

We have decided to cancel the provider's registration to carry on the regulated activity of accommodation for persons who require personal or nursing care.