

Greenleaf Healthcare Limited

# Livesey Lodge Care Home

## Inspection report

Livesey Drive  
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Leicester  
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Tel: 01455273536

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## Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

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

Livesey Lodge is a residential care home providing accommodation and personal care to 12 people aged 65 and over at the time of the inspection. The service can support up to 24 people.

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

The service was still not well-led, and lessons not learnt from previous shortfalls we identified. Serious ongoing concerns were identified in the day to day management and oversight at the service.

The registered managers attendance at Livesey Lodge was inconsistent and infrequent. They had only been present 9 of the previous 77 days to the inspection. No alternative arrangements had been put in place in their absence, instead care workers with no managerial experience were left to manage the service in their absence. This contributed to the widespread failings in the leadership and governance arrangements.

Staff did not receive adequate support and guidance from registered persons and were not listened to if they raised any issues.

Staff were assigned to multiple roles including cooking and cleaning due to a lack of consistent staff. Staffing levels meant people did not have opportunity to engage in regular meaningful activities.

A staff member was left to arrange the deployment of staff but had no authority to make changes to the levels of staff if they were needed.

The registered manager held no records staff were fully vaccinated for COVID-19 in line with government guidance. This increased the risk of a further outbreak of the virus. Protocols for visiting professionals did not include checks of their vaccination status.

Policies, such as infection control and safeguarding were not always reviewed, updated or contained the correct information.

Support, advice and guidance the service received from other agencies was not acted upon and opportunities missed to make improvements to service delivery and management.

Without exception people and relatives praised the safe care and treatment they received from care staff. Staff knew people well and held positive relationships with them. Observations during the inspection confirmed the feedback we received.

Risks to people health were safely managed. People were supported with their food and nutrition and their medicines managed safely.

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](http://www.cqc.org.uk)

#### Rating at last inspection and update

The last rating for this service was inadequate (published 27 April 2021) and there were two breaches of regulations and a recommendation made in relation to the provision of activities. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had still not been made and the provider remains in breach of regulations.

#### Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Livesey Lodge on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### 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 have identified breaches in relation to management and governance, infection control procedures, staffing and person-centred care at this inspection.

Due to the repeated breaches and failure to make improvements to exit special measures enforcement action was taken against the provider to remove their registration.

## 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 effective?

**Requires Improvement** ●

The service was not always effective.

Details are in our effective findings below.

### Is the service caring?

**Requires Improvement** ●

The service was not always caring.

Details are in our caring findings below.

### Is the service responsive?

**Requires Improvement** ●

The service was not always responsive.

Details are in our responsive findings below.

### Is the service well-led?

**Inadequate** ●

The service was not well-led.

Details are in our well-led findings below.

# Livesey Lodge 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 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

The inspection was carried out by one inspector and an 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

Livesey Lodge 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 service had a manager registered with the Care Quality Commission. This means that they 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

This inspection was unannounced.

#### What we did before the inspection

We reviewed information we had received about the service since the last inspection. 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 this information to plan our inspection.

#### During the inspection

We spoke with two people who used the service and five relatives about their experience of the care provided. We spoke with seven members of staff including two senior care workers, care workers and the cook and housekeeper. The registered manager did not make themselves available for the inspection.

We reviewed a range of records. This included two people's care records medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found.

# 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 inadequate. At this inspection this key question has now remained the same. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection; Learning lessons when things go wrong

At our last inspection the provider failed to ensure people were protected from the risk of infection and systems were either not in place or robust enough to ensure infection prevention measures were safely managed. This was a breach of Regulation 12 (Safe care and 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 12

- The providers infection control policy had been reviewed on 1 June 2020. However, the policy was generic, not specific to Livesey Lodge, and did not include measures put in place to address the increased risks associated with COVID-19. No reference to any of the government guidance was included from the onset of the pandemic, and the COVID-19 service risk assessment had still not been updated following our previous inspection.
- The local authority infection prevention and control team visited the service on the 2 November 2021 as a follow up to their initial visit in April 2021 following an outbreak of COVID-19. 31 recommendations were made following the visit and the report concluded that 'IPC practice at the service was not in line with best/national practice'.
- The senior care worker told us and there were no records to confirm action had been taken to implement any of the recommendations made. This meant the provider had missed opportunities to improve infection control at the service despite a previous outbreak of COVID-19. This placed people at an increased risk of harm if a further outbreak of COVID-19 occurred.

We found no evidence that people had been harmed however, infection control systems and processes were either not in place or robust enough to demonstrate risks of acquiring infectious diseases was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People, staff and visitors were placed at risk of acquiring infectious diseases including COVID-19.
- Government guidance for the requirement for visiting professionals to have received both doses of an approved COVID-19 vaccine from 11th November 2021. The senior care worker on duty was unaware of this requirement. During the inspection the requirement for visiting professionals to have their vaccination status checked was added to the COVID-19 screening protocol at the home.
- Government guidance for staff working in the service is to have received both doses of an approved COVID-

19 vaccine from the 11 November 2021. Staff could evidence they had received two vaccine doses and further evidence was provided by partner agencies following the inspection.

- There was, however, no system and process in place to record staff vaccination status and this could increase the risk of the service deploying staff without the appropriate vaccination status in the future.

- We were assured that the provider was meeting shielding and social distancing rules.
- 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 accessing testing for people using the service and staff.

#### Staffing and recruitment

- Despite assurances following the previous inspection staff rotas would identify the person in charge we found they still did not. The day to day responsibility of managing the service appeared to be left with whichever of the two senior care workers were on duty. Both senior care workers confirmed this when we sought clarification.
- When we reviewed staff rotas and COVID-19 screening protocols for entry to the service, they showed the registered manager had only been present at the service for 9 of the previous 77 days. Examples included 1, 2, 3, 10, 17, 30 November and 1 December where the rota confirmed the registered managers attendance, but no COVID-19 screening protocol was completed. For all other staff they matched.
- Staff told us at the previous inspection the registered manager had not always been present at the service when rotas showed they were. At this inspection evidence of this remained.
- No formal mechanism was in place to assess the number of staff required to meet people's needs safely. A senior care worker informed us they had responsibility for the deployment of staff. They told us, "The number of staff on duty is always the same. I don't have authority to make changes and we [senior care workers] try and manage the best we can but have to assign different staff to different roles including ourselves.
- There were not enough cleaning and cooking staff employed by the service. In the absence of these staff, care workers were deployed to undertake these as part of their shift and meant care delivery could be compromised.

We found no evidence people had been harmed however, the lack of oversight, planning and deployment of staff was not in place. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection we observed people's needs being met in a timely way. Staff attended to people promptly when they requested support.
- Staff were recruited safely with Disclosure and Barring Service (DBS) checks completed to ensure they were suitable to work in a care service.

#### Systems and processes to safeguard people from the risk of abuse

- There continued to be shortfalls in safeguarding and whistleblowing policies despite these being identified at our previous inspection.
- A new safeguarding policy had been implemented but it still did not contain contact details of partner agencies including the local authority or CQC for reporting and alerting safeguarding concerns to. This meant there was a risk these agencies may not always be informed as legally required, and people were at risk of not being protected from the risk of harm and abuse. However,
- A senior care worker the registered manager delegated to report concerns was aware of which agencies should be informed. All the staff we spoke with confirmed they recognised signs of abuse and would report



them.

- The whistleblowing policy had not been reviewed as scheduled to be in August 2019. The policy stated the next review was March 2023 with no record it had been reviewed since August 2019. This meant 3 ½ years would have elapsed before the next review was undertaken.
- Staff knew the whistleblowing procedure but remained concerned action would not be taken to address any concern raised.

We found no evidence people had been harmed however, effective safeguarding policies and procedures were not in place. This placed people at risk of harm. 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.

- All the people and relatives we spoke with told us they received safe care. One person told us, "I have been a resident here for a long while and have never felt unsafe." A relative told us, "[Name] feels safe. They have always told me this and I have no concerns either."

#### Assessing risk, safety monitoring and management

- People remained without COVID-19 risk assessments within care plans to identify support they may require in the event of having to self-isolate from contracting COVID-19. We previously identified a person who was anxious and lonely from isolating in their bedroom during an outbreak of COVID-19. The continued lack of risk assessments to support people in the event of a further outbreak meant people's well-being was still not considered, and staff were still not effectively guided on how to reduce the impact.
- All other identified risks to people were assessed and reviewed when their needs changed, for example following an incident. Staff clearly knew people well and told us how they monitor people in line with the risks they faced.
- People commented how staff had supported them to access services for equipment, such as walking aids, to help keep them safe whilst retaining their independence. We saw one person had continual access to their walking aid throughout the inspection.

#### Using medicines safely

- Staff received training in administering medicines safely and whilst they told us their competency was checked we found no records to support this.
- Medicines were managed safely. We saw medicine administration record (MAR) charts were in place, these showed people received their medicines as prescribed.
- Regular checks of medicines were in place to monitor stock levels and ensure they were being given correctly.
- When people were prescribed medicines 'as and when required' (PRN), the correct protocols were in place to inform staff when to administer these medicines. Records confirmed when and why they had administered PRN medicines.

# 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 now deteriorated to requires improvement. 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

- The registered manager and provider did not provide adequate support to staff. Senior care workers were frequently left to manage the service on a day to day basis with minimal support despite their lack of managerial experience.
- Staff told us they needed support but did not receive it. Staff said the current arrangements had become the 'norm' and they were unaware if this arrangement would change in the foreseeable future. One staff member told us, "We need a manager here to support us". Rotas corroborated the frequent lack of presence at the service of the provider and registered manager.
- Supervisions and appraisals were sporadic and unstructured, and staff relied on each other for support.
- Staff were experienced and had received training in a range of areas. However, records did not show when training was scheduled to be refreshed or reviewed.

Adapting service, design, decoration to meet people's needs

- Whilst the service was homely and welcoming it required investment and refurbishment. For example, window blinds needed replacing and carpets were worn. One person told us, "The décor needs improving here."
- People's rooms were personalised with mementos and personal effects.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People received a full assessment of their care needs prior to moving to the service by a senior care worker. Assessments detailed people's wishes including their cultural, lifestyle and spiritual needs.
- Assessments were undertaken with the person at the centre of the process. Relatives and other agencies involved in people's care were also part of the process.

Supporting people to eat and drink enough to maintain a balanced diet

- People's nutritional needs were met. Where people's diets required monitoring, records confirmed this was undertaken.
- People were supported with their meals. Staff sat with people at mealtimes helping when they needed it.
- Staff supported people to make their meal choices taking care to ensure these met dietary requirements.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Changes in people's health was promptly identified by staff and referrals were made to healthcare professionals when required.
- Staff worked in partnership with external agencies including GP's and health care agencies.

#### 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.

- Mental capacity assessments and best interest decisions had been completed for individual decisions people were unable to make for themselves.
- The service was working within the principles of the MCA and restrictions on people's liberty had been authorised.
- People's consent to their care and support was always obtained. We observed staff seeking people's consent to care before providing support.

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

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

- The provider did not always ensure people were well treated. There was still no consideration to any impact upon people from having to self isolate in the event of an outbreak of COVID-19. Furthermore, staffing levels did not enable care workers to support people beyond their direct care needs. This meant people's well-being was not always protected.
- People and their relatives gave overwhelming positive feedback of the kind caring and compassionate care provided by care staff. One person told us, "The carers are so kind and lovely and look after me and everyone else here very well in my view. I am a lot more independent than most here and am able to see this all the time." A relative told us, "They [carers] really do care, which is so nice to see however busy they are."
- We saw warm interactions between staff and people living at the service. Staff could describe how they supported people to ensure they felt safe and secure. We saw friendly conversations between people and how staff used their knowledge and understanding of people to support them sensitively.
- Staff told us they treated people as individuals and knew how people like to spend their day and knew people's routines and how they endeavoured to meet them according to their wishes.
- People and relatives were involved in planning of their care. One relative told us, "We were very much part of this when [Name] moved in and the care plan. This was important for [Name] and us as a family."
- Records confirmed people were involved on how they wished to spend their time on a typical day and the importance of their possessions. For example, one person had a doll with them throughout the inspection. Staff told us this was crucial for the person as it relaxed them and reduced any anxiety they may be experiencing.

Respecting and promoting people's privacy, dignity and independence

- Where staff identified people in communal areas required support with their personal care, they were mindful of the importance of protecting their dignity and privacy. They approached people in a sensitive manner encouraging and supporting them to their rooms so not to alert others to their need of intrusive care.
- Staff knew what people could do for themselves and their care plans reflected their level of independence.
- People were supported to maintain relationships with family and friends.

# Is the service responsive?

## Our findings

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

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

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

We made a recommendation at the last inspection the provider develop regular meaningful activities for people. At this inspection no action had been taken and people remained without access to regular meaningful activities.

- The provider had taken no action to ensure people had access to meaningful activities. Staff had minimal time to support people to engage in activities due to their time being afforded to their caring responsibilities.
- We observed people who were consistently sat in communal areas with no stimulation other than interactions with care workers. One staff member told us, "There is no activities person. We do what we can if we have any spare time."

The provider had not acted following on our previous recommendation to provide people with opportunity to engage in meaningful activities. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were detailed and included people's history and preferences and reviewed regularly or when people's needs changed by senior care staff. These staff told us the registered manager was unable to accurately review them as they were not familiar with people's needs.
- Staff read people's care plans and used the information contained within them to support people safely and according to their needs and wishes. One staff member told us, "I read the care plans and have input into them. They contain lots of information."
- People and relatives were involved in planning and reviewing their care needs. One relative said, "Yes I am aware of the Care plan and I am involved in its review. My impression is they are receptive to input I make."

Improving care quality in response to complaints or concerns

- There was a complaints policy in place which was conspicuously displayed in the service. A complaints log was in place which showed there were no current complaints.
- People and their relatives were encouraged to raise concerns and were confident they would be listened to and acted on. One person told us, "A senior member of staff told me 'feel free to mention anything you are concerned about'." A relative said, "I have no complaints, but I know it wouldn't be a problem taking

anything up, the carers are so open with me."

#### 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 had been assessed and included in their care plans.
- Staff were aware of people's communication needs and adapted their interactions so they understood information and could reliably express themselves. For example, we observed staff using different pitch and tone of their voice for people with a hearing impairment.

#### End of life care and support

- Records confirmed end of life wishes were discussed and care planned for where people and relatives chose to do so. Staff were mindful of the sensitivity of planning and discussing end of life support with people.
- Nobody was receiving end of life care at the time of our inspection, however staff were trained to support people through end of life care with compassion and dignity.

# 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 inadequate. At this inspection this key question has now remained the same. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

At our previous inspection the service was not effectively managed with systems and processes either not in place or robust enough. This was 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.

- The serious shortfalls identified in relation to the management and governance of the service at our previous inspection remained. People and staff were placed at risk from the continuing frequent absence of both the provider and registered manager at the service. Inexperienced staff were regularly left in charge of the service with minimal support.
- Records, and staff feedback confirmed the registered manager had only attended the service for 9 of the previous 77 days to the inspection. No reason or explanation was offered by the provider or registered manager for their lack of presence at the service following the inspection. Staff told us they needed regular managerial support on site. Staff were reliant on telephone support. One staff member told us, "We need a manager here."
- People raised concerns regarding the management of the service. One person told us, "This place [Livesey Lodge] is managed by the carers. The [registered manager] is not here often and when they are, they seem to find fault but never do anything about it. I feel sorry for them [carers]."
- Relatives also raised their concerns over the management of the service. One said, "A lot of the time they [registered manager] are rarely there and it's left to the other staff who are really good." A further relative said, "It [Livesey Lodge] 'survives' because of the quality and dedication of the staff. A carer said to me, 'as soon as I finish one thing there is two more waiting to be done'."
- The registered manager had not ensured government guidance was followed in relation to checking and recording staff and visiting professional's vaccination status. The infection control policy contained incorrect information, the COVID-19 risk assessment for the service had still not been updated and people remained without COVID-19 risk assessments. This meant there was an increased risk of another outbreak of COVID-19.
- There was no mechanism in place to assess the number of staff needed to meet people's needs. A senior

care worker told us there was a pre-determined level of staff to which they were required to complete rotas against. This led to staff being required to undertake multiple roles at the service which we had identified at our previous inspection.

- Staffing pressures combined with the lack of activities meant people were not provided with any meaningful occupation of their time.

We found no evidence that people had been harmed however, the lack of management and governance arrangements in place meant the service was not safely managed. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Notwithstanding all the concerns and shortfalls we identified, all of the people and relatives told us the care and treatment staff provided was kind and compassionate. Our observations supported this view.

Working in partnership with others; Continuous learning and improving care

- Opportunities to improve the service had been missed and concerns we had previously found remained. There were no plans in place to address the concerns we identified
- Support and advice from partner agencies to improve aspects of the service's quality and safety had not been addressed. Staff showed us a recent report with recommendations from a previous visit by the local authority had not been followed up.

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

- Staff told us they were not supported or involved in the service and saw little point in raising concerns as they were not listened to.
- People and relatives were involved in the planning and reviewing of their care and were able raise any concern with care staff who were responsive to them.

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 duty of candour is a set of specific legal requirements providers of services must follow when things go wrong with care and treatment.
- There had been no notifiable safety incidents since the last inspection required the registered manager to act under duty of candour. Senior staff we spoke with on inspection were open and honest with us during the inspection.



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 provider had not ensured people had access to meaningful activities. Enforcement action taken to remove the providers registration.

### The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider had not done all that is reasonably practical to assess and mitigate potential risks to people's health and welfare. Enforcement action taken to remove the providers registration.

### The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment  The provider had not implemented effective safeguarding policies and procedures. Enforcement action taken to remove the providers registration. Enforcement action taken to remove the providers registration.

### The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The provider had not ensured there was effective leadership and governance at the service.

Enforcement action taken to remove the providers registration.

**The enforcement action we took:**

Notice of proposal to cancel registration

**Regulated activity**

Accommodation for persons who require nursing or personal care

**Regulation**

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider did not have oversight and effective arrangements in place for the deployment of staff. Enforcement action taken to remove the providers registration.

**The enforcement action we took:**

Notice of proposal to cancel registration