Beling & Co Limited

Wensley House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Our previous comprehensive inspection to the service was on 16 and 17 January 2018. The overall rating of the service at that time was judged to be 'Requires Improvement'. A breach of Regulation 9 [Person-centred care], Regulation 12 [Safe care and treatment] and Regulation 17 [Good governance] with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was made. At this inspection the required improvements had not been made.

Wensley 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. Wensley House Residential Home provides accommodation and personal care for up to 48 older people. Some people also have dementia related needs.

The inspection was completed on the 3 and 4 December 2018 and was unannounced. At the time of the inspection, there were 32 people living at Wensley House Residential Home.

The service did not have a registered manager in post. The service was being managed by a deputy manager and the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Quality assurance checks and audits were not robust, they did not identify the issues we found during our inspection and had not recognised where people were placed at risk of harm and where their health and wellbeing was compromised. The registered provider was unable to demonstrate overall responsibility and scrutiny of what was happening within the service to make the required improvements. The lack of managerial oversight had impacted on people, staff and the quality of care provided. Therefore, they were unable to demonstrate where improvements to the service were needed, how these were to be made and had been addressed; and lessons learned to ensure compliance with regulatory requirements and the fundamental standards.

Although people told us they were safe, the service's previous manager had failed to notify the Local Authority and Care Quality Commission of two safeguarding incidents and internal investigations were poorly completed and provided insufficient evidence to back-up the findings and outcome.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered, and risk assessments had not been developed for all areas of identified risk. Care records were not maintained to ensure staff were provided with clear up to date information which reflected people's current care needs. Where people were judged to be at the end of their life, information relating to their end of life care needs

were not recorded. Improvements were required to the service's medication arrangements as discrepancies relating to staff's practice and medication records were found.

The management team had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people using the service, others were not respectful or caring and failed to ensure people received the care they required. People were not supported to participate in meaningful social activities. Improvements were also required to people's overall dining experience as the support provided was not always provided in a respectful and dignified manner.

People's capacity to make day-to-day decisions had been considered and assessed. Nonetheless, improvements were required to ensure staff had a better understanding of the main principles of the Mental Capacity Act and best interest assessments completed for all areas.

Not all staff had received a comprehensive robust induction and the role of senior members of staff was not effective in monitoring staff's practice and providing sufficient guidance and support. Most staff had attained up-to-date training but improvements were required to ensure this was embedded in their everyday practice.

The service worked with other organisations to enable collaborative joined-up care and ensure people's healthcare needs were met. The registered provider's arrangements for the prevention and control of infection at the service was satisfactory. Safe recruitment practices and procedures were in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks were not identified for all areas of risk. Risks were not suitably managed or mitigated to ensure people's safety and wellbeing and improvements were required relating to medicines management.

Effective safeguarding arrangements were not in place as investigations were not robust.

There were sufficient numbers of staff available to meet people's care and support needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff induction arrangements were not as robust as they should be and not all staff training was embedded in staffs practice.

Where people required assistance and support to eat and drink, this was not always provided in a respectful and dignified manner.

People's healthcare needs were met and people were supported to have access to a variety of healthcare professionals and services as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People using the service did not always receive good quality care or treated with respect and dignity. Care provided was primarily task focused and 'service-led' rather than person-centred.

Staff did not always effectively communicate with people using the service, particularly people living with dementia.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed to ensure all of a person's care and support needs were recorded and the information up-to-date and accurate.

Where appropriate, people did not have end of life care plans in place.

People were not supported to participate in a range of social activities.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken appropriate measures to address concerns raised at the previous inspection.

Systems to measure the quality of the service did not identify the concerns and risks to people that we found as part of this inspection.

Wensley House Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 4 December 2018 and was unannounced. On both days the inspection team consisted of two inspectors. On 3 December 2018 the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

We reviewed the information we held about the service including safeguarding alerts and other statutory notifications. This refers specifically to incidents, events and changes the registered provider and registered manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people who used the service, eight people's relatives, four members of care staff, the service's chef, the staff member responsible for maintenance at the service, the deputy manager and the registered provider.

We reviewed six people's care plans and care records. We looked at the staff recruitment records for four members of staff, staff training information for the service, supervision and appraisal records. We also looked at the service's arrangements for the management of medicines, safeguarding, complaints and compliments information and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

Not all risks were identified and suitable control measures put in place to mitigate the risk or potential risk of harm for people using the service. Risk assessments were not consistently completed to evidence how risks to people were to be managed and lessened. The care records for one person detailed they could be anxious and distressed; and this could impact on others. A risk assessment was not in place to show how this was to be managed to ensure the person's and others safety and wellbeing. No risk assessment was completed relating to one person whose mental healthcare needs were at risk of deteriorating placing them at risk of self-harm.

We found six freestanding wardrobes did not have a retaining bracket to prevent the furniture falling, or being pulled forward with a potential to cause significant injury and harm. The registered provider was advised to review all rooms where wardrobes were located and to take appropriate remedial action to ensure peoples safety.

On the second day of inspection one person was observed trying to mobilise with a walking frame. Although this was allocated to them it was not set at the correct height. The person was observed trying to maintain a comfortable upright position, however their hands could barely reach the walking frame. Staff were unaware of the inappropriateness of this item of equipment and the potential risks this posed to the person whilst they mobilised. We discussed this with the deputy manager and following our inspection a healthcare professional was contacted; the person's mobility needs reviewed and their walking frame replaced.

We looked at the Medication Administration Records [MAR] for 10 of the 32 people who resided at the service and found discrepancies relating to staff's practice and medication records. The MAR forms for six people documented they were prescribed a topical cream. This is a moisturising treatment applied directly to the skin at regular intervals. On the second day of inspection, when we visited 10 people's bedrooms, we noted they had a topical cream, either in their room or within their en-suite facility. Though a topical cream chart was in place, this was inconsistently completed to evidence if this had been applied by staff in line with the prescriber's instructions. For example, one person's chart detailed this should be applied each day by staff but between 18 October 2018 and 4 December 2018 [48 days], there were no entries recorded for a total of 31 days. The MAR form for another person confirmed they were prescribed a short course of antibiotic. The MAR form detailed 14 tablets were prescribed and received, however only 13 tablets were signed as given. A rationale for this discrepancy was not recorded and the deputy manager was unable to provide a reason for this.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated an understanding of the different types of abuse and how to escalate any concerns about a person's safety to the registered provider and external agencies such as the Local Authority and Care Quality Commission. However, following a review of the service's safeguarding information, the Local Authority and Care Quality Commission were not notified by the service's previous manager of two

safeguarding incidents in June 2018. One concern suggested staff had regularly assisted a person to eat and drink despite the person having their eyes closed and being asleep. Although an internal investigation had been completed, the information was poorly completed and provided insufficient evidence to back-up the findings and outcome. The other concern referred to a specific incident whereby one person's mental healthcare needs had deteriorated and placed themselves at significant risk of self-harm because of their suicidal thoughts. We discussed this with the registered provider and they confirmed they had not been made aware of either issue by the service's previous manager. This demonstrated robust procedures and processes that make sure people are protected were not in place or effective.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. One person told us, "I feel safe here because people talk to you." Another person told us, "Yes, I do feel safe here because staff are kind to you." All relatives spoken with confirmed they had no concerns about their family member's safety and wellbeing.

People told us there were sufficient numbers of staff available to provide the support required to meet their care and support needs. Staff confirmed there were sufficient staff on duty, to undertake their roles and responsibilities and to meet people's needs. Observations demonstrated the deployment of staff within the service was suitable and people's call alarm facilities were answered in a timely manner.

Staff recruitment records for three members of staff were viewed. Staff recruitment procedures showed relevant checks were carried out before a new member of staff started working at the service. These included processing applications, including a full employment history and exploring any gaps, obtaining written references, ensuring the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service [DBS]. Prospective employee's equality and human rights characteristics were also recorded and considered when recruiting staff. Improvements were required to ensure any conflicts of interest were considered. For example, the application form for one employee had not been written by them and one reference was from a relative.

The service managed the control and prevention of infection well and staff followed best practice procedures when working. Where malodours were noted staff were quick to respond and housekeeping staff understood how to maintain good hygiene.

Requires Improvement

Is the service effective?

Our findings

A copy of the staff training plan was requested and provided. The staff training plan confirmed most staff employed at the service, had attained up-to-date mandatory training in line with the registered provider's expectations and this consisted both 'face-to-face' and online training. However, not all training was embedded in staff's practice. This related to how staff supported people who were living with dementia, supporting those who found it difficult to verbally communicate and who could become anxious and distressed. Relatives did not feel assured all staff employed at the service were appropriately trained, particularly in relation to living with dementia.

Although newly employed staff received an 'in-house' orientation induction, these arrangements were not as robust as they should be to meet staff members support requirements or to prepare staff for their role. Whilst two newly appointed members of staff had previous experience in a care setting, they had not attained a National Vocational Qualification [NVQ] or qualification undertaken through the Qualification and Credit Framework [QCF] and had not commenced the 'Care Certificate' or an equivalent industry recognised induction. The registered provider confirmed this as accurate but was unable to provide a rationale for the discrepancy. Staff told us they felt supported and received supervision at regular intervals.

People's comments about the quality of meals provided were positive. One person told us, "The food is wonderful." A second person confirmed this as accurate by saying, "I enjoy the food here and we have a good choice." Relatives were also positive and comments included, "The food here is very good and my relative has put on weight" and, "My relative has never complained about the food, it always looks nice when served." We spoke with the chef but were concerned about their lack of knowledge and understanding relating to people's specific dietary needs and did not seemingly know what 'fortifying' a diet meant. The chef confirmed they were not fortifying people's meals. We made the registered provider and deputy manager aware of the latter.

People were not rushed to eat their meal and were able to enjoy the dining experience at their own pace. However, where people required assistance and support to eat and drink, this was not always provided in a respectful and dignified manner. Staff did not always remind people of their chosen meal or what they were eating. Staff did not always stay with the person they were assisting to eat and on occasions were observed a staff member leave for a period and then return without providing an explanation to the person they were supporting.

Staff demonstrated a good understanding of people's individual nutritional needs and how these were to be met. Staff were aware who had swallowing difficulties, required their meals to be pureed and required a thickening powder to aid their swallowing difficulties and minimise the risk of aspiration. The nutritional needs of people were identified and, where people who used the service were at nutritional risk, referrals to a healthcare professional such as the GP, dietician and Speech and Language Therapist [SALT] had been made. Where instructions recorded that people should be weighed at regular intervals, this had been followed to ensure their nutritional and hydration needs were being monitored and any concerns were picked up at the earliest opportunity.

People told us their healthcare needs were well managed. Relatives confirmed they were kept informed of their member of family's healthcare needs and the outcome of any healthcare appointments. Care records showed people's healthcare needs were recorded, including evidence of staff interventions and the outcomes of healthcare appointments. Improvements were required to ensure where advice and guidance was provided by a healthcare professional, this information was transferred to the person's care plan.

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 the mental capacity to make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's capacity to make decisions was assessed and recorded, but not all assessments had been reviewed and a best interest assessment had not been completed where people had a sensor alarm mat in place. The latter is put in place for people who are at risk of falls and this alerts staff when a person mobilises.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. Staff demonstrated a basic knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

Requires Improvement

Is the service caring?

Our findings

People told us staff cared for them in a kind and considerate way. One person told us, "The staff are really kind to you here." A second person using the service told us, "The care staff help me to wash and dress and they always speak to me nicely." However, people told us, staff did not sit and talk with them and not all relatives felt they got answers to their query's or staff fully understood their family member's care and support needs, particularly in relation to supporting people living with dementia. One relative told us, "I feel the staff are kind and caring but I am not sure they [staff] understand dementia." A second relative told us, "I think staff do know [relative's] needs but not sure about their dementia." A third relative told us they were not assured that staff always understood the needs of the person they supported. They told us their relative had been observed to be asleep in their chair and a member of staff attempted to give their family member a cup of tea despite their eyes being shut. When queried with the member of staff, they stated they were trying to wake the person up.

Observations demonstrated not all people using the service received care that met their needs, or was kind and caring. On the first day of inspection one person was observed to be seated within the 'garden' lounge which was located to the rear of the service. Over a 15-minute period the person was overheard to repeatedly call out and the person's behaviour suggested they were distressed. An agency member of staff was observed to assist two people to eat their lunch at this time. The agency member of staff did not enquire if the person was alright or to ask them what support they required. During this time another staff member entered the same lounge and spoke to four people, enquiring if they were alright and asking them if they had enjoyed the lunchtime meal. The interactions were positive; however, the staff member did not speak with the person who continued to call out, even though they were still visibly distressed.

Another person was seated within the main lounge which was located adjacent to the dining room. Prior staff bringing them their lunchtime meal, the person appeared distressed and anxious as they were overheard to express concern about their comfort needs being met. Following a discussion with staff it was confirmed the person was wearing continence aids. However, our observations showed the person remained seated in the same chair for a continuous period of five hours and 15 minutes, without being asked or supported to have their comfort needs met. The person's care plan recorded, 'Staff will encourage [name of person using the service] to use the toilet regularly.' This did not happen in practice.

The same person was provided with their lunchtime meal. A member of staff was observed to assist the person to eat, however shortly after assistance was provided, the person became distressed and anxious. They told the member of staff they did not wish to eat anymore and though this was stated on several occasions, the member of staff continued with the task. This meant despite the person's objections, their views, wishes and preferences were ignored and not listened to. Because of this the person became verbally challenging by raising their voice and threatening to hit the member of staff. The member of staff stood up, provided no explanation to this person, walked away and aided another person using the service to eat their meal.

On both days of inspection, staff interactions with people using the service, were primarily task orientated,

focussing on providing people with a drink, meals and meeting peoples' comfort needs. The examples as detailed above, showed people received a lack of person-centred care that was appropriate to meet their care and support needs. There was an over reliance on the television and music, despite people being predominately either asleep or disengaged with their surroundings and not watching the television. Staff did not sit and talk with people for a meaningful length of time and staff interactions did not always ensure people got the support they needed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's independence was promoted and encouraged according to their capabilities and abilities. People told us they could manage some aspects of their personal care with limited staff support. They also confirmed if they needed assistance this would be provided. Many people were observed to eat and drink independently.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Relatives confirmed there were no restrictions when they visited and they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

People's comments about social activities provided at the service were not favourable. One person told us, "All I do is sit here, I am surprised I have not gone funny, but I do talk to the person next to me." Another person told us, "I love it when we have a sing song. I used to go dancing but we don't often have anything going on here to do." A third person stated, "I just sit here most of the day looking at the television." Relatives confirmed what people told us. One relative said, "They never have much going on here for the residents, just some music most days and the television on. They [people using the service] need more stimulation." Another relative stated, "Very little goes on here, no stimulation for the residents, it is very disappointing."

The service was without a member of staff specifically responsible for facilitating social activities for people living at the service. The registered provider and deputy manager confirmed it was their expectation that all care staff were responsible for facilitating activities until an appropriate person was recruited and appointed. Observations during the inspection showed limited opportunities were provided for people to participate in meaningful social activities and there was an over reliance on the television and music. Throughout the first day of inspection the same two CD's played repeatedly. On the second day of inspection the television within the 'garden' lounge was not audible for people to hear as the CD player within the main lounge was loud and could be overheard. This was the second consecutive inspection whereby people had limited opportunities to participate in meaningful social activities. On the second day of inspection religious observance was completed and children from a local school visited the service to sing Christmas carols and songs. The latter was observed to be a very positive experience and people told us they had really enjoyed the children's singing.

Although the deputy manager had made improvements to the service's care planning arrangements, improvements were still required to ensure care plans fully reflected people's holistic care and support needs and provided sufficient guidance for staff as to how these were to be met. For example, the care plan for one person detailed they could be anxious and distressed. No information was recorded detailing known triggers and guidance for staff relating to the support required to manage their behaviours to ensure positive outcomes. Another person's care plan referred to them having two healthcare conditions, however a care plan relating to how this impacted on their day-to-day activities of daily living and the support required by staff to keep them safe was not recorded.

The deputy manager told us two people were judged as requiring end of life care. There was no evidence to suggest either person was not receiving appropriate care, but neither person had an end of life care plan in place, including advanced directives. The latter sets out if the person has expressed a wish to be cared for at the service or to go to hospital and if potential treatment options have been discussed with their GP or relevant healthcare professionals. No information was recorded relating to pain management arrangements, how the person's end of life care symptoms was to be managed to maintain their quality of life as much as possible and the use of pre-emptive medication. For example, a small supply of anticipatory medicines for symptom control as the person actively deteriorated had been supplied by the GP surgery but no information was recorded detailing when this should be used.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place for people to use if they had a concern or were not happy with the service. People told us they would speak to their relative or staff if they had any concerns. Not all relatives felt their concerns and complaints would be properly dealt with. One relative told us, "I have made a number of complaints, sometimes you get feedback and other times you do not." A second relative told us, "You can complain to the owner [registered provider], they listen to you but I feel it goes over their head." A record was available detailing the specific nature of each complaint. Improvements were required to show if a thorough investigation had been completed, actions taken and outcomes. A record of compliments was maintained detailing the service's achievements.

Inadequate

Is the service well-led?

Our findings

Since our last inspection to the service in January 2018, the management arrangements at Wensley House Residential Home had changed. The manager had left the employment of the service in August 2018. The service did not have a registered manager in post and was being managed on a day-to-day basis by the deputy manager and overseen by the registered provider.

The culture of the service was not positive and systems in place did not always promote a 'person-centred' culture that centred on people's needs or valued them as individuals. The care and support delivered by staff was not consistent to ensure people received safe care and support and there was a lack of oversight from the provider. Staff practices were not monitored to ensure people received safe care, were always treated with respect and dignity and ensuring care provided was 'person-led' rather than 'service-led.' Staff employed in a senior role were not effective role models as they failed to provide clear direction and support to staff to enable them to undertake their responsibilities to a good standard.

Quality assurance arrangements which assessed, monitored or improved the quality of the service remained ineffective since our last inspection in January 2018. Although some systems were in place they had not highlighted the areas of concern we identified. Areas which required improvement, for example, robust investigations of safeguarding concerns, medication practices, care planning and risk management arrangements, ensuring people had the opportunity to participate in social activities and monitoring staff practices, were not picked up by the registered provider's quality assurance arrangements.

The registered provider was unable to explain the arrangements in place to assure themselves that the service was operating safely and in line with regulatory requirements. The previous manager who was employed at Wensley House Residential Home from 21 August 2017 to 6 August 2018 was held responsible by the registered provider for existing failures at the service.

Whilst the registered provider visited the service regularly, formal arrangements to monitor and assess the quality and safety of the service were not in place. The registered provider told us they had relied solely on what was told to them by the previous manager. The registered provider stated they were told by them that everything "was in hand." No arrangements were in place for the previous manager to actively report to the registered provider, to inform them where the service was compliant, non-compliant or where improvements were still required. The registered provider confirmed the action plan submitted to the Care Quality Commission following the last inspection in January 2018 had not been updated and kept under constant review.

The personnel file for the previous manager was not available to view and the registered provider confirmed no formal supervisions were conducted with them from the time they were appointed in August 2017. This was despite the service having an overall quality rating of 'requires improvement' and three breaches of regulation identified following our last inspection to the service in January 2018.

Prior to the manager leaving the employment of Wensley House Residential Home in August 2018, an

external consultant was employed by the registered provider to monitor what was happening within the service and to report their findings to them. The registered provider could not confirm the number of visits undertaken by the external consultant and when we asked to see the reports, we were told these were unavailable and were no longer available on the service's computer system. We asked the registered provider if they could obtain the reports directly from the external consultant and forward these to the Care Quality Commission. These reports were not provided.

Although there were several audits and checks in place, where issues were highlighted, an action plan detailing how these were to be addressed and managed were not completed. For example, weekly medication audits confirmed topical emollients were not being recorded to evidence these had been applied to people using the service by staff. Infection control audits for August 2018 and November 2018 evidenced only 58% of compliance had been achieved. Despite issues with the service's care planning arrangements, care plan audits had not been completed since July 2017. Monthly audits relating to falls, accidents and incidents were completed but the information recorded was not analysed to monitor potential trends and lessons learned. No information was recorded detailing how this was to be managed and improvements made.

Staff meetings had been held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Minutes of the meetings confirmed this and although a record had been maintained, where matters were highlighted for action or monitoring, it was not possible to determine how these were to be or had been monitored and the issues addressed. Meetings for relatives were also held but these were infrequent.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 People using the service did not always receive person-centred care that was appropriate to meet their needs. Assessments did not include all of their needs.

The enforcement action we took:

Imposed condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way and risks to people were not always recorded detailing the specific risks and how these were to be mitigated.

The enforcement action we took:

Imposed condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the quality of the service provided.

The enforcement action we took:

Imposed condition