Mr & Mrs A Cousins

Levanto Residential Care 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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Levanto Residential Care Home (hearafter referred to as Levanto) is a residential care home providing accommodation and personal care to up to 20 people. The service provides support to older people who are living with dementia. At the time of our inspection there were 16 people using the service.

Accommodation is provided over the first and second floors, with the registered manager and deputy manager's office being on the third floor. The second floor is serviced by chair lifts. Some bedrooms have ensuite facilities. There are two communal lounges and a dining room. There is a small veranda at the front of the property with comfortable seating.

People's experience of using this service and what we found
Several staff members had raised concerns about abusive and neglectful practice with the registered manager, who is also the provider. They had done this verbally, in writing, and by whistleblowing to the Care Quality Commission (CQC). The registered manager did not take these concerns seriously and failed to effectively investigate them, despite some of the concerns alleging physical and emotional abuse. During the course of this inspection, several staff members disclosed they had witnessed staff inflict physical and verbal abuse upon people.

We raised safeguarding concerns with the local authority in relation to eleven people, and about the service as a whole. We also shared our concerns with the police and other agencies. The local authority responded by initiating a large-scale safeguarding adults enquiry.

There was a closed culture at the service. CQC guidance on closed cultures and the impact they have on peoples' human rights identifies 33 warning signs of a closed culture. 21 of these warning signs were evident at Levanto. For example, staff not understanding or speaking warmly about the people they were caring for, care plans not reflecting peoples' voice, people being restricted from moving around freely and staff not receiving training that enables them to meet the needs of and effectively safeguard people. One person's family member told us, "Once the person is in Levanto (registered manager) has the overriding thing of looking after the person, instead of their family doing so."

Staff did not always treat people with respect. They talked loudly to each other about people, within their hearing, and were not respectful when people expressed their needs. One person's family member told us their loved one had said the staff "were not very nice to them." We observed people to be bored, disinterested and to have little interaction with staff. We asked one person if they liked living at the service, they said, "Not really, I'm left on my own most of the time."

Known risks were not well assessed, monitored or managed which put people at risk of harm. Care plans did not contain enough information to enable staff to mitigate risks to people or give important guidance, such as how to help people move safely. Risks relating to pressure damage, falls and choking were not well

managed. There was no evidence any action had been taken in relation to peoples' weight loss, which put them at risk of malnutrition. Medicines were not always stored securely or administered in line with best practice. Staff recruitment systems were not operated effectively or in line with legal requirements. This meant people were at risk of being supported by unsuitable staff.

The risk of the spread of infection was not well managed because good infection control practice was not being followed. Staff had not completed any training in relation to Covid-19. People were being supported to have visitors and we saw people visiting on both days of our inspection. This had not, however, been communicated to all family members and one person's relative told us they were frustrated they could not visit.

Staff did not receive appropriate support, training or professional development. It was evident from our observations of staff practice they did not have the training and skills to support people safely and meet their needs. Equipment was not well maintained, and the environment did not support peoples' independence. Two people had heavily stained and dirty, poor condition, sprung mattresses on their beds. The environment had not been adapted for people living with dementia. There were no signs to help people orientate themselves within the building and nothing to identify peoples' bedrooms. One person told us, "I don't know where anything is."

Peoples' needs were not always assessed prior to them arriving at the service. Ongoing assessments were not always accurately completed, and care was not delivered in line with current evidence-based practice and standards. Staff did not follow healthcare professionals' advice and did not recognise when it was appropriate to seek further support. Staff made decisions about the type of equipment people should use without the knowledge or qualification to do so, which put people at risk of harm.

People were not given a choice of food at mealtimes and staff made decisions for them. We observed two people in their bedrooms for long periods of time with no drinks within reach. Staff told us people were sometimes rushed at mealtimes and told to hurry up. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Peoples' care plans were task focussed and contained limited information about peoples' personal preferences. People and their families were not supported to be involved in their care planning or express their views. One family member told us, "One carer told me off for giving my relative chocolate marzipan. I thought that it was rude and that she was treating me like a child." There were routines in place which did not reflect peoples' individual needs. People were not supported to have regular baths or showers and there were no systems in place to monitor oral healthcare.

There were no systems in place to identify, record or respond to complaints. Complaints were not investigated. The registered manager told us they did not accept verbal complaints and did not take notice of anonymous complaints. One family member told us, "You have to pick your battles with [registered manager]."

Staff told us that managers were not responsive, did not listen to their concerns, feedback or suggestions for change. One staff member told us, "(Registered manager) is very much the boss, it's got to be 'their way', it's very difficult to try and change things when someone is so set in their ways." Concerns raised by staff were not investigated thoroughly and confidentiality was not maintained. This led to a culture of bullying. Peoples' families did not feel the culture of the service was open. One relative said, "It is difficult to ask for information – you are made to feel like you are a difficult relative." When we challenged the registered

manager and other managers in the service about poor practice, they, at times, became defensive and hostile. We observed managers did not role model positive or professional behaviour to staff throughout the inspection.

The service was not open and transparent. They did not identify or recognise where people were subject to abusive or degrading treatment or where incidents between people constituted a safeguarding concern. The service did not work in partnership with others. In some cases, staff worked in direct opposition to the advice given by healthcare professionals. They did not communicate well with families about peoples' health needs.

The registered manager was not aware of any of the concerns identified on this inspection. They considered they provided a "specialist dementia home" and told us, "We feel we do everything we can." They told us they felt let down by their staff but failed to recognise their own failings in identifying the shortfalls.

Notifications were not sent to CQC in line with legal requirements. This included notifications of allegations of abuse and serious injury.

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

Rating at last inspection
The last rating for this service was good (February 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the safety and quality of care people received, safeguarding, complaints, staffing, infection control, nutrition, record keeping and the leadership of the service. A decision was made for us to inspect and examine those risks.

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

We have found evidence that the provider needs to make significant improvements, some of which were urgent. We shared our concerns with the local authority safeguarding team and other agencies. Please see the safe, effective, caring, responsive and well led sections of this full report.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

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

Enforcement and Recommendations
We have identified breaches in relation to safeguarding; safe care and treatment; premises and equipment; person-centred care; dignity and respect; consent; staff training and recruitment; complaints; notifications and governance and leadership at this inspection.

We cancelled the providers registration.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority and other agencies to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.	**Inadequate**
Is the service effective? The service was not effective	**Inadequate**
Is the service caring? The service was not caring	**Inadequate**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well led.	**Inadequate**

Levanto Residential Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was conducted by two inspectors, a medicines inspector, an assistant 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
Levanto Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Levanto Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We reviewed a range of records including three staff recruitment files, audits tools, records relating to safety, training, supervision, policies and procedures. We reviewed six peoples' care records in detail and sampled additional records. We checked nine peoples' medicines records and looked at arrangements for administering, storing and managing medicines. We spoke with 13 people living at the service and 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 comment directly on their care. We spoke with 12 peoples' family members. We sought feedback from eleven health professionals and received feedback from four. We spoke with 20 members of staff, including the registered manager (who is also the provider), deputy manager, care manager, care staff, domestic and auxiliary staff.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes did not protect people from abuse. Several staff members had raised concerns about abusive and neglectful practice with the registered manager, who is also the provider. They had done this verbally, in writing, and by whistleblowing to the Care Quality Commission (CQC). The registered manager failed to effectively investigate these concerns, and dismissed them as 'staff falling out', despite some of the concerns alleging physical and emotional abuse.

● On day one of our inspection we witnessed a person stand up repeatedly. One staff member told them to "sit down" every time they stood up, and on three occasions physically pushed the person back into their chair with force.

● Staff spoke unkindly about people. One staff member told us a person living with dementia was "naughty" and referred to them as "the nasty little one". A second staff member told us this person was, "A nasty little [gender]."

●Relatives and staff told us people were not supported to mobilise safely. We observed this and were told of examples where people were physically lifted by staff under their arms. This put people at risk of harm and staff did not recognise this as a safeguarding concern.

● One person's family member told us their relative said staff shouted at them. They reflected that at times their relative had seemed quite frightened, and they had themselves experienced "abruptness" from one staff member. Another person's family member said, "Mum has a few bruises on her wrist – in my mind finger marks."

● An accident audit completed in March 2022 documented one person had pushed another person over, resulting in a hospital admission and a fractured bone. This was not recognised or reported as a safeguarding incident and the service did not report it to the local safeguarding team. The service had not informed the persons family of the circumstances of the fall.

● Comments from family members included, "Some carers are not who you would want to care for your relative", "Carers forget that people are human beings, and not pieces of flesh", "(Name) does moan and groan about one nurse", and "(Name) does complain about the home."

● During the course of this inspection, several staff members disclosed they had witnessed staff inflict physical and verbal abuse upon people. We raised safeguarding concerns with the local authority in relation to nine individual people, and about the service as a whole. We also shared our concerns with the police.

● The providers safeguarding policy stated, 'Where a member of staff is the alleged abuser, they should be suspended by the registered providers immediately in line with the homes disciplinary policy.' The registered manager had failed to adhere to this policy when allegations were bought to their attention. They also failed to notify the local authority and CQC.

● The registered manager did not take the concerns staff raised with them seriously. When we raised our

concerns about the lack of a thorough investigation, they became defensive and said they trusted their staff. They said they didn't need to investigate any further than asking them if allegations made against them were true, and considered the staff members raising concerns were causing trouble.

Systems and processes were not operated effectively to protect people from abuse and neglect. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● Known risks were not well assessed, monitored or managed which put people at risk of harm. Care plans did not contain enough information to enable staff to mitigate risks to people.

● One person's care plan said their fluid intake should be restricted for medical reasons. Despite this being clearly recorded in both their care plan and hospital discharge record, staff did not monitor their fluid intake. The care manager told us they didn't know the person's fluids should be restricted and staff recorded 'fluids pushed' within their care notes. Staff did not understand or consider the risks to the person's health.

● Two people were assessed as being at high risk of pressure damage and required regular repositioning to mitigate this risk. Their care plans did not tell staff how often or how they should be assisted, and no repositioning records were being completed. Staff told us they needed to be repositioned every two hours. Repositioning records were put in place following our feedback on day one of our inspection. These showed regular gaps of three and four hours. This increased peoples' risk of developing pressure damage.

● Another person's risk assessment had been incorrectly completed and had assessed their risk of pressure damage as being lower than it was. Their family member told us, "I have complained that [Name] says that he has a sore bottom, they say he has no sores … he has been bed bound for months. I have asked if he can have a pressure mattress, but it hasn't happened – they have no hoist. He has said that he would rather be dead than just lie there." The provider said the person was always complaining about a sore bottom but had not ensured timely action was taken to reduce their pain and reduce further damage.

● One person's weight record showed they had lost 40.2kg over the past 24 months, which was almost half of their body weight. A second person had lost 8.7kg in the past six months. There was no evidence that any action had been taken in relation to people's weight loss, which put them at risk of malnutrition.

● A member of staff told us one person had been very unwell and lost a lot of weight, and this meant they could now assist them out of bed because they were lighter in weight. We observed the person to be out of bed and use a wheelchair to go to the dining room for meals. Their care plan did not contain any detail about how staff should assist them to move. We asked a staff member how they assisted them, they responded "by lifting." Manual lifting is not safe practice and put the person at increased risk of physical harm.

● One person's care plan contained a letter from a health professional which said. 'I would like to reiterate that [Name] should be transferred with a full body hoist at all times.' We saw that staff did not follow this advice. The hoist was stored in the outside shed and not easily accessible to staff. A staff member told us they manually lifted the person and did not use equipment to transfer them. They said, "They're tiny, they're easy, they can't weight bear or stand." This person's moving and handling risk assessment said the person didn't like the hoist and 'in our opinion it could be very detrimental to their health if the hoist is used.' No further advice from health professionals had been sought.

● Several staff members told us one person choked and coughed when drinking. Their care plan did not contain any information about thickening their fluids to reduce the risk of choking or aspirating. We asked staff if they thickened this person's drinks. Some told us they did, and others told us they didn't. Health professionals told us the person had been assessed as requiring thickened drinks in September 2020. However, the service had never ordered the prescribed thickener from the pharmacy. Some staff used prescribed thickener, which belonged to people who no longer lived at the home, to thicken the person's drinks because they were worried about the person choking, however, because other staff did not use it, this

meant the person had been at an increased risk of choking or aspirating for 21 months.
● Risks relating to falls were not well managed. The care manager told us there was one person at high risk of falls, however care records indicated at least three people were. Staff described people 'walking around' the home all day. We observed people being unsteady as they got out of chairs. People did not always use walking aids and clung onto bannisters and walls.
● We saw poor staff practice when assisting people, for example, walking backwards holding peoples' fingers. There were long periods of time where people were left unsupervised by staff. There were no accessible call bells in the lounges so people could not call for assistance. This put people at an increased risk of falls.
● Two people were at increased risk because their care plans did not contain any detail about the risks associated with diabetes. For example, foot and eye care. One person's care plan contained no guidance for staff to help them monitor their blood sugars. One care entry recorded their blood sugar was 7.1, with no context of why this was recorded, what it meant for the person or what action staff had taken.

Risks were not well assessed, monitored or managed and people were at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always stored securely. The medicines fridge was not locked, and the full temperature range was not recorded. This meant we were not assured these medicines were always stored at the correct temperature to be safe and effective for people.
● On day one of our inspection we saw one person's cream charts had five gaps where no information had been recorded. On day two of our inspection, these five gaps had been completed retrospectively, which is not in line with best practice and meant we could not be sure if the person had their creams administered or not.
● One person had creams in their room which had not been prescribed for them and had expired in August 2021, which meant they were potentially ineffective. A second person had creams prescribed to another person in their room, along with two containers of cream with the prescribing label ripped off.
● We saw that food supplements were stored in an open cupboard in the dining room and were visible to residents. There was no risk assessment to show this was safe for people living in the home.
● Other medicines were stored safely, including those needing extra security. However, when controlled drugs were signed out of the home, for example when returned to the pharmacy, these were not always signed out in the register by two members of staff.
● One person's medicine record chart was full and there were no records to show whether one of their medicines had been administered for the previous three days.
● Improvements were needed to the way 'when required' medicines were managed. There were no person-centred protocols available to guide staff when doses might be needed, and no records of the time or reason for administration when these were given.

Medicines were not managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records showed that most regular medicines were given in the way prescribed for people.

Staffing and recruitment
● Staff recruitment systems were not operated effectively or in line with legal requirements. There was no dependency tool in place to ensure there were enough staff to meet people's needs.
● Appropriate references were not always sought. Disclosure and Barring Service (DBS) checks provide

information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. No records of DBS checks were kept.
● One staff member was employed without a recent DBS check.
● Application forms did not request a full work history, gaps in employment were not explored and no interview records were kept.
● One staff member had a negative reference from a previous employer. There was no record of any discussion regarding this.

Systems and processes to ensure staff were recruited safely were not operated effectively. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The risk of the spread of infection was not well managed. We observed poor mask wearing practice by a number of staff on the first day of inspection, including staff sitting directly next to people with their mask under their chin. One member of staff did not wear a mask at all.
● Good infection control practice was not being followed. For example, the use of hand towels in communal bathrooms rather than disposable hand towels. This increased the risk of cross infection and was not in line with best practice.
● A sign in the laundry said there had been 'a spate of faeces being found in the washing machine.' The sign directed staff to soak soiled linen in salt water before washing, which was not in line with best practice and put people at risk of cross infection.
●The layout of the laundry meant staff collecting peoples' clean clothes had to walk through the area where soiled clothes were kept. There was also a large food storage room accessed at the back of the laundry. Staff collecting the food items had to walk through the area where soiled clothes were kept. This increased the risk of cross infection.
● We observed one staff member return from assisting a person in the toilet still wearing their gloves. They proceeded to assist the person to transfer without removing them.
● Staff did not follow the service's infection control policy, which said temperatures should be taken on entry to the building. Staff did not request to check the inspectors' temperature on either day of inspection.
● Staff had not completed any training in relation to Covid-19. A risk assessment dated April 2022 indicated staff had been required to work when Covid positive, due to staff shortages, during a recent outbreak.

The risk of infection was not well managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● People were being supported to have visitors and we saw people visiting on both days of our inspection. This had not, however, been communicated to all family members and one person's relative told us they were frustrated they could not visit. They said, "There was a long stage of us not being allowed in due to Covid, I asked them to let me know when they are open again – they haven't."

Learning lessons when things go wrong
● There were no processes in place to review safeguarding concerns or incidents. The provider had poor oversight of the care people received and failed to identify where things went wrong.
● Multiple concerns had been raised by some staff, people living at the home and families regarding the poor attitude and unsafe or abusive practice of several staff members. The provider had not learnt lessons from these concerns. Instead, they continued to allow these staff to work at the home with inadequate monitoring or formal disciplinary action.

● Systems in place to identify where improvements could be made were ineffective. For example, a medicines storage audit completed in March 2022 failed to identify the medicines fridge was broken and could not be locked.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff did not receive appropriate support, training or professional development.
- Induction paperwork consisted of a 'tick list' of questions for staff to answer with yes or no. For example, 'Are you aware of the needs of the people you will be supporting.' This did not demonstrate staff completed a robust induction prior to supporting people.
- The induction paperwork contained reference to out of date legislation. For example, the Data Protection Act 1998, which was superseded by the General Data Protection Regulations (GDPR) in 2018.
- We asked staff to tell us about the induction they completed. One said they, "looked at the signs in the shed." Others couldn't remember completing one.
- The deputy manager used 'training supplement' booklets for staff training. The information within these booklets was of poor quality and lacked detail. For example, the infection control training booklet did not contain any information about Covid-19.
- The dementia training booklet only contained information about one type of dementia and used outdated language, for example 'dealing with aggression'. The booklet focused on 'coping mechanisms' for staff and lacked any detail about how to support people in line with best practice. It was evident from the way staff interacted with people that they had a poor understanding of current best practice in dementia care.
- Despite the training booklets clearly stating they were 'designed to complement staff training', staff were issued certificates for completing them. One member of management had completed an assessor's qualification in 2002 and felt this gave them the qualification needed to deliver and assess training. However, they acknowledged they had not completed any training themselves for a long time and had not kept their own knowledge up to date.
- Staff told us they could not remember when they last completed face to face training. One staff member, who had worked at the service for three years, told us they had, "never had any practical training".
- A number of staff had not completed training recently. For example, ten staff had not completed safeguarding training since November 2020, and falls training had not been completed since 2018.
- Eight staff had not completed any moving and handling theory training since June 2020. There was no record of any staff completing practical moving and handling training and no competency assessments were completed. This was reflected in the poor practice we observed and were told about by staff and by people visiting the home.
- No members of staff had completed any training in pressure area care or dysphagia. Dysphagia training enables staff to safely support people with an impaired swallow.

● Staff supervisions were being completed approximately every six months. These focused on the same limited questions each time and did not follow up or record issues that had been identified. For example, the registered manager told us they had had concerns regarding one staff member's conduct and had spoken to them on several occasions. This was not addressed during their supervisions which recorded them as working well.
● There was no record of any appraisals being completed which meant staff had no opportunity to review their overall progress or identify any longer term goals and training needs.
● One person's family member told us, "The girls are not properly trained." Another said, "Carers need more external training on dementia – people need to be spoken to in a welcoming tone, touched, and given time to process what has been said to them."

Staff did not receive appropriate support, training or professional development.
This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Premises and equipment were not kept clean; equipment was not well maintained, and the environment did not support peoples' independence.
● Poor maintenance of some areas of the building made effective cleaning difficult. For example, warped tiles in a communal toilet and broken tiles in the laundry. The laundry had not been kept clean. The environment was cluttered and there was thick dust on the pipes and cobwebs on the walls.
● Two people had heavily stained and dirty, poor condition, sprung mattresses on their beds. We asked one person if their bed was comfortable, they said, "No, it's got lots of hard lumps in." They told us this caused them discomfort.
● Equipment was not well maintained. We saw one wheelchair being used with no cushion in it. The arms of the wheelchair were heavily torn exposing the foam inside, this meant it could not be cleaned properly and increased the risk of cross infection.
● There were no cleaning schedules in place. Despite having recently experienced an outbreak of Covid-19, high touch points weren't being regularly cleaned. A staff member told us they wiped them "if they look sticky".
● Equipment was being stored in places which impacted on peoples' ability to use the space. For example, an upright hoover was being stored in a communal toilet, a large standing hairdryer was being stored in one person's ensuite and two wheelchairs were being stored in another person's room.
● The environment had not been adapted for people living with dementia. The carpets were heavily patterned, which can cause visual disturbances and increase the risk of falls. There were no signs to help people orientate themselves within the building and nothing to identify peoples' bedrooms. One person told us, "I don't know where anything is."
● One person's family member told us, "I don't think the décor is right for people with dementia, there are new things they could do to improve it. It's in need of modernisation."
● There was no secure outdoor space for people to use, although the provider acknowledged some people were "outdoor people."

Premises and equipment were not well managed. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● There was limited evidence of staff working with other agencies to meet peoples' needs.

● One person's risk assessment showed they were at high risk of pressure damage and were cared for in bed 24 hours a day. We asked staff why the person had been allocated a foam mattress, rather than an air mattress, which would be in line with best practice for the person's level of risk. They told us they had tried an air mattress, but the person didn't like it. We asked if they had sought advice from occupational therapists, staff responded, "No, we don't ask."
● This person had been in bed for a long time. Their care records said this was their choice, because they were scared of using the hoist. When we spoke with the person and asked if they would like to get out of bed and go downstairs, they said, "I'd very much like that." There was no evidence that staff had involved other health professionals to support the person or seek support with managing their anxiety around using the hoist.
● Staff did not follow healthcare professionals' advice and did not recognise when it was appropriate to seek further support. For example, where people had experienced significant weight loss.

Staff did not work effectively with other healthcare professionals in order to ensure they met people's needs and preferences. This was a breach of regulation 9 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
● Peoples' needs were not always assessed prior to them arriving at the service. Ongoing assessments were not always accurately completed, and care was not delivered in line with current evidence-based practice and standards.
● One person had been given notice to leave the service, because the service found they could not meet their needs. This was despite them only being admitted weeks before and their needs being clearly stated on the information provided by the local authority.
● Assessments were not reviewed and there were no checks to ensure care was being delivered in line with people's assessed needs.

Peoples' needs were not always assessed. This was a breach of regulation 9 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 food at mealtimes and staff made decisions for them.
● There were no menus on the dining tables, and staff did not offer sauces or condiments. Staff talked constantly through the mealtime and there was loud pop music coming from the kitchen.
● When we spoke with the registered manager about the lack of choice offered to people, they said they "did not feel it would be practical" to ask people what they wanted to eat. They also said, "It would be problematic if people changed their minds," and that "they would forget anyway".
● We observed two people in their bedrooms for long periods of time with no drinks within reach. Neither of these people were able to call for assistance or mobilise to reach their drinks.
● Staff told us people were sometimes rushed at mealtimes and told to hurry up.
● People were not given a choice about where they ate their meals. One person's family member told us their relative was "not allowed to stay in her room for meals, even breakfast, so that meant that a frail old [gender] had to use the stairs six times a day."
● Another person's family member told us their relative, "Seems to enjoy the food, but they're as thin as a rake, they tell me she eats well but I am worried about the weight loss."

People were not supported to have a choice that meets their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The food looked appetising and people seemed to enjoy their meal.
● The cook told us they would always be willing to make alternatives if people requested them and had begun to introduce more options in response to our feedback. They told us people were "well fed".

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People were not always supported in the least restrictive way possible or in line with the codes of practice associated with the MCA.
● Capacity assessments relating to specific decisions, such as bed rails, were completed. These decisions were recorded as being in peoples' best interests in line with the MCA. However, they did not always adequately consider the risks to the person as part of the decision-making process. For example, staff had made a best interest decision that one person should have bed rails on their bed without completing a bed rails risk assessment or considering the risks they might pose to the person. The decision to use bed rails put the person at risk of harm and was not in their best interest.
● Staff did not always use the least restrictive option to mitigate risks to people. For example, people were prevented from moving around the home or choosing where they spent time. We saw some people being repeatedly told to sit down. They had nothing to occupy them and they were restless.
● Staff did not always consider peoples' capacity when supporting them. For example, one person who was living with dementia had previously used a chair to try and climb over the railings of the balcony, which put them at risk of serious injury. When we expressed concern after observing the person to be alone on the same balcony, a staff member said, "Obviously if they want to go out there, I can't stop them." They did not consider if the person had the capacity to keep themselves safe, or their duty of care to that person if they did not.

People were not always supported in the least restrictive way possible or in line with the codes of practice associated with the MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Mental capacity assessments were completed and applications to deprive people of their liberty were made where appropriate.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not treated with dignity and respect.
- Staff did not speak kindly to people or about people and did not always treat them with respect. For example, staff used the word 'bib' to describe clothes protectors; a notice on the wall said, 'residents feeding list', and people requiring a modified food texture to minimise the risk of choking were referred to as 'the softs.'
- Staff talked loudly to each other about people, within their hearing. We heard one staff member shout "She's just been toilet" about a person, in front of other people in the communal lounge.
- Staff were not respectful when people expressed their needs. We observed one person ask a staff member to help them use the bathroom, the staff member responded, "Wait till I drink my coffee" and left the room.
- On another occasion a person asked a different staff member if her incontinence aid could be changed. The staff member responded, "Yep yep, that's fine", but walked away and did not help the person.
- One person's family member told us their loved one had told them the staff "were not very nice to them." Another person had told their family they were shouted at by staff.
- People were not supported to have regular baths or showers. Records showed most people had a bath or shower weekly, however some people had large gaps in their records. One person had gaps of nine, 13, 20, 22 and 44 days between baths or showers. Another person went almost six months with no baths or showers recorded.
- There were no systems in place to monitor oral healthcare. We saw toothbrushes in some peoples' rooms that were brand new and unused. Others were dirty and clogged up with old toothpaste. We saw two peoples' teeth looked unclean. One person's family member told us they had bought mouth wash for their relative because their teeth were in poor condition and their breath smelt bad on occasion. They had also bought them an electric toothbrush. When we checked this was out of charge and had not been used.
- We observed five peoples' hair to be unkempt and unbrushed throughout the second day of inspection. This undermined their dignity.

People were not treated with dignity or respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some staff were kind and we saw some caring interactions. We heard one staff member say, "I love caring for you (name)." This staff member was also observed being very patient and encouraging one person to take some pain relief.

● One person living at the home told us the care was excellent. They were more physically able than some other people and went out regularly with friends and family.
● Some peoples' family members were more positive. One said their relative "appears to be happy", another said, "Staff are very good." A third told us, "Staff are lovely."

Supporting people to express their views and be involved in making decisions about their care
● People were not supported to be involved in their care planning or express their views.
● Peoples' families were not involved in care plan reviews. Feedback from peoples' families included, "There was a care plan done in the beginning – but there have been no reviews", "I don't know anything about a care plan – I have not been involved" and, "I don't know anything about a care plan."
● Peoples' family members were not supported to be partners in care. One family member told us they were, "Asked by a member of staff to not help my mum with her lunch in the dining room, which I was quite offended by." Another said, "One carer told me off for giving my relative chocolate marzipan. I thought that it was rude and that she was treating me like a child."

People were not supported to be involved in their care planning or express their views. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Peoples' care plans were task focussed and contained limited information about peoples' personal preferences.
- On the second day of inspection we observed the morning handover from night staff to day staff. This detailed if people had been 'changed', 'toileted' and 'repositioned', but there was no detail shared about how most people had spent the previous evening or how people were feeling.
- There were routines in place which did not reflect peoples' individual needs. For example, everybody had a 'bath day' once a week. We saw repeated notes in the diary that staff should not wash one person's hair. The deputy manager told us this was because their bath day was the same day the hairdresser came, and staff repeatedly washed their hair even though it had just been done by the hairdresser, ruining the style. This approach showed staff were task orientated and therefore did not consider the individual needs of that person or how they looked.
- Peoples' care records contained directions such as 'night staff to give breakfast', and there was a 'breakfast list' for staff to follow, rather than asking people what they would like. People were given "social drinks" at set times. We observed one person express dislike of the drink they were given. A staff member offered to get a replacement, but the person said, "That'll be just as bad. Disgusting. It was supposed to be coffee, but it wasn't."
- We saw another person asking to have their breakfast. Staff told them they had to wait because they needed time after taking their medication before eating. When we checked the person's medicines this was not a prescribing direction from the GP. The person became increasingly distressed and repeatedly told staff they were hungry and wanted their breakfast. Later in the morning they told us they were still hungry and were not sure if they had their breakfast. We told a staff member who suggested they have a cup of tea. We suggested the staff might make them some more breakfast, and they gave the person a bowl of porridge. The person had to tell staff three times that they didn't like porridge and wanted Weetabix, whilst staff talked between themselves about what the person 'had'. The breakfast list said they preferred toast.
- Staff were not responsive to individual needs, repeatedly telling people to sit down. Senior staff did not role model good practice, frequently talking over people and about people in front of them or in communal spaces.
- Staff only engaged with people if they were completing a task, with limited meaningful interaction.
- Staff told us people walked around all the time, however, they did not relate this to people being bored, or their needs not being met.
- There was no call bell in the communal areas and people were left for long periods of time with no staff supervision. This increased the likelihood of potential clashes between people. We saw one person try to physically guide another whilst commenting on their body. The person being 'guided' grimaced and looked

uncomfortable. We saw other people look fearful of others when they came near them.
● Staff locked peoples' bedroom doors during the days and decided where people could spend their time. One persons' family member told us, "We mainly see mum downstairs in the lounge as she is not allowed upstairs. This makes her very agitated and is upsetting for all of us. We do ask if she can go upstairs but are told no. I believe the manager wants her upstairs, but the staff don't."

Care was not person-centred. This was a breach of regulation 9 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
● We observed people to be bored, disinterested and to have little interaction. We asked one person if they liked living at the service, they said, "Not really, I'm left on my own most of the time." Another person said, "Not much now, I just sit about" in response to the same question. A third person said, "I'm not staying here all day and all night it'll drive me (expletive) crackers." Other comments included, "I'm fed up of this (expletive) place." "Not much fun just sat in a chair all day" and, "I'm fed up, about everything."
● Peoples' care plans did not contain any information about peoples' cultural interests or how staff could support them to take part in activities.
● On the first day of our inspection there was a music activity taking place in one of the communal lounges. We asked a staff member why four people in the second communal lounge weren't taking part. They told us they didn't like music. We asked one of these people if they liked music, and they responded, "Yes I do, thank you very much." When we asked why they didn't go and join in they said, "I'm stuck here, I don't know how to get there do I."
● One person's family member told us, "They had animals in – which was lovely, but they did not include my [family member], he was in his room." The person's care records said, '(Name) no longer participates in the in-house activities.' Another person's family member said, "They all look pretty bored out of their minds."
● A third person's family member told us staff sometimes put the radio on for their relative, however this was "not often on the station she would like." A fourth person's family member commented, "[relative] seems contained in her room. She spends a lot of time alone. I wish they would integrate her and encourage her to socialise."
● Daily records rarely recorded peoples' emotions or wellbeing. There were no records kept in relation to activities. One manager told us it was a "bug bear" how little information the care records contained, and that they had "asked and asked" for them to be more detailed.
● People spent long periods of time without staff speaking to them.
● When staff did interact with people, it was not always positive for them. One staff member tried to get a person to catch a ball, despite the person clearly telling them they physically couldn't. The staff member walked away and said, "I'll have to find someone else then." Prior to this interaction the person had been quite happy and engaged watching the television. This showed the staff member had not properly observed them and recognised they did not need to be interrupted. The staff member did not speak to anyone else in the room and walked out.
● One person spent their time in the bedroom, and often called out and talked aloud. A staff member told us they were not interested in other people. We found that not to be the case. This person engaged with inspectors and reached out for physical contact. Their eyes lit up when the inspector went to speak with them for a second time, engaging with us, giving eye contact and smiling.

People were not supported to develop relationships or avoid social isolation. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● There was poor planning for peoples' end of life, and care plans were not personalised.
● A staff member told us one person had been receiving end of life care, but their health had improved significantly. Despite this, there was no personalised detail in their end of life care plan, for example their wishes, what comforted them, such as music or what worried them, such as pain. Instead, it concentrated on the details of their Treatment Escalation Plan (TEP) which were about medical treatment.
● Under the section for spiritual needs in the person's care plan it stated, '[Name's] spiritual/religious needs are adhered to and this will continue when they require 'end of life' care and the home would welcome any religious services that their family feel would be personal to them as a family.' Generic statements did not show how the person had been consulted, for example, what spiritual/religious beliefs they held.

End of life care and support was not personalised. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● There were no systems in place to identify, record or respond to complaints. Complaints were not investigated.
● The service complaints policy did not contain contact details for the registered manager/provider. It contained out of date contact details for the Local Government Ombudsman and was not on display in the service.
● No complaints had been recorded and the registered manager told us there had not been any. The registered manager told us they did not accept verbal complaints and did not take notice of anonymous complaints.
● Concerns raised by staff were not recorded as complaints. One staff member told us they didn't feel there was any point making a complaint about the abuse and poor practice she witnessed because, "Other people have expressed things and they've got nowhere; it falls on deaf ears." One family member told us, "You have to pick your battles with [registered manager]. I have fought a number of battles." A second persons' family member said they had challenged staff about having to book visits. They told us, "I was made to feel like I have no rights as a relative and told to take it up with [registered manager], I was appalled to be treated like that."
● A third family member said, "I reported this incident (regarding person entering their family members room and ripping a family photo, which caused them distress) to one of the carers, who advised me she was aware that this particular resident was a challenge and they were waiting for him to be moved to another home. She asked me to complain to the owner because, in her words, nothing will happen if you don't complain." There was no record of this complaint.

Systems to identify, record and respond to complaints were not established or operated effectively. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● There was limited information about peoples' communication needs. Care plans focussed on whether people wore glasses or hearing aids.

● Staff had not considered alternative ways of communicating with people, such as using pictures or small sample meals, to help people who were unable to read a menu make a choice about food.
● By the second day of our inspection, some picture communication cards had been purchased. It was not clear however how these would be used with and how they had assessed them as being appropriate.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The culture of the home was not positive, open, person-centred or inclusive and people did not experience good outcomes.
- There was a closed culture at the service. CQC guidance on closed cultures and the impact they have on peoples' human rights identifies 33 warning signs of a closed culture. 21 of these warning signs were evident at Levanto. For example, staff not understanding or speaking warmly about the people they were caring for, care plans not reflecting peoples' voice, people being restricted from moving around freely and staff not receiving training that enables them to meet the needs of and effectively safeguard people.
- One person's family member told us, "Once the person is in Levanto (registered manager) has the overriding thing of looking after the person, instead of their family doing so." A staff member said, "The (registered manager) is very much the boss. It's got to be their way."
- Staff told us managers were not responsive, did not listen to complaints, feedback or suggestions for change. One told us, "(Registered manager) is very much the boss, it's got to be 'their way'. It's very difficult to try and change things when someone is so set in their ways."
- Concerns raised by staff were not investigated thoroughly and confidentiality wasn't maintained. This led to a culture of bullying. For example, one staff member told us they had confidentially raised concerns about a colleague with the registered manager. They told us the registered manager told their colleague what they had said. This led to an argument where the colleague shouted and swore at them in front of people living at the service. This made them fearful of raising any further concerns.
- Another staff member had raised concerns anonymously via CQC. They told us that when they went to work after raising the concerns, the staff they had raised concerns about were sat with a printout of their concerns, loudly discussing how "disgusting" the person who raised them must be, which made them feel intimidated.
- When CQC had previously raised concerns with the registered manager/provider, the registered manager focussed on trying to identify who had contacted us and assumed complaints were malicious. Responses included, "We had been trying to wrack our brains as to who would be so nasty as to make the complaint." In response to one concern the registered manager told us, "Any in-house complaint would be investigated by management." At this inspection we found this not to be the case.
- Peoples' families did not feel the culture of the service was open. One said, "It is difficult to ask for information – you are made to feel like you are a difficult relative." Another told us, "There is poor communication, we are not kept informed, no emails."
- When we challenged the registered and deputy managers about poor practice, they, at times, became

defensive and hostile. We observed that managers did not role model positive or professional behaviour to staff throughout the inspection.

The culture of the home was not positive, open, person-centred or inclusive and people did not experience good outcomes. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Managers did not understand quality performance, risks and regulatory requirements.

● The registered manager and deputy manager were not aware of any of the concerns identified on this inspection. They considered that they provided a "specialist dementia home" and told us, "We feel we do everything we can." They told us they felt let down by their staff but failed to recognise their own failings in identifying the shortfalls.

● The registered manager told us they spent significant periods of time talking with people living at the service, and "lived and worked among the staff and residents' day and night" for the bulk of the Covid-19 pandemic. They had, however, failed to identify any of the concerns found during this inspection.

● Quality assurance systems in place were not effective. The deputy manager completed a monthly managers audit. However, this did not include sampling care monitoring records, analysing incidents or checking the care people received was in line with their care plans. They had failed to identify people did not have access to the right equipment, that people were at risk of pressure damage and choking or that staff were not supporting people in a person-centred way.

● The roles and responsibilities shared between the management team were disjointed. The deputy manager was responsible for completing and reviewing peoples' risk assessments and care plans; however, they did not provide care to people and did not know people well. They relied on the care manager telling them if peoples' needs had changed, however, the care manager didn't always know what was in peoples' care plans. For example, they were unaware one person's fluid should be being restricted.

● There was no effective provider oversight of the service. The registered manager, who was also the provider, had delegated responsibility for management of the service to the deputy manager and care manager. They did not perform any quality checks themselves and had limited knowledge of where information was stored or what peoples' needs were.

● Policies and procedures had been reviewed, but managers failed to identify they contained out of date or inappropriate information and did not always follow best practice.

● Peoples' care records were kept in an unlocked cupboard in the communal dining room, and daily care notes and monitoring records containing personal information, such as peoples' weights, were not securely stored. This meant the provider was not compliant with GDPR regulations.

Managers did not understand quality performance, risks and regulatory requirements. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications were not sent to CQC in line with legal requirements. This included notifications of allegations of abuse and serious injury.

This was a breach of regulation 18 of the Care Quality Commission (Registration) regulations 2009.

● Some staff and family members gave more positive feedback. One staff member said they felt managers were approachable. One person's relative said, "I get on with the (registered manager), they're nice and chatty." Another person's family member said, "If there is anything serious, they do ring me."

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There were no systems in place to support continuous learning and improving care.

● There were no systems in place to engage people using the service or understand their experience of the care they were receiving.

● Managers told us they were not part of any local networks and had not accessed training and support offered by the local authority.

● One person's family member told us, "I haven't seen any changes, their attitude is if it's not broke, don't change it!"

● There was no service improvement plan in place.

There were no systems in place to support continuous learning and improving care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Surveys were sent to some family members to gather feedback and we saw three had been returned with positive feedback, however, other family members told us they hadn't received one.

Working in partnership with others

● The service did not work in partnership with others.

● In some cases, staff worked in direct opposition to the advice given by healthcare professionals. For example, failing to use the correct equipment to help people transfer.

● Staff did not always recognise when they should involve other health professionals when peoples' health declined, or their needs changed.

The service did not work in partnership with others. This was a breach of regulation 17 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 service was not open and transparent. They did not identify or recognise where people were subject to abusive or degrading treatment, where incidents between people constituted a safeguarding concern, and did not communicate well with families about peoples' health needs.

● One person's family member told us there had been a delay in notifying them when their relative had an injury, and they 'couldn't remember' being told by staff that their family member had been pushed over by another person.

● Another person's family member told us they had not been informed of a pressure sore their loved one had until it "was down to the bone".

● Other feedback included, "She gets repeated UTI's, antibiotics are ongoing, they don't let me know", "They do let me know if they call a doctor – but I don't get feedback."

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 Care was not person-centred. Peoples' needs were not always assessed. People were not supported to be involved in their care planning or express their views. Staff did not work effectively with other healthcare professionals. People were not supported to have a choice that meets their needs and preferences. People were not supported to develop relationships or avoid social isolation. End of life care and support was not personalised.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity or respect.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always supported in the least restrictive way possible or in line with the codes of practice associated with the MCA.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Risks were not well assessed, monitored or managed and people were at risk of harm. Medicines were not managed safely. The risk of infection was not well managed.

The enforcement action we took:

We cancelled the providers 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 Systems and processes were not operated effectively to protect people from abuse and neglect.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not well managed.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems to identify, record and respond to complaints were not established or operated effectively.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Risks were not well assessed, monitored or managed and people were at risk of harm. Medicines were not managed safely. The risk of infection was not well managed.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems and processes to ensure staff were recruited safely were not operated effectively.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, training or professional development.

The enforcement action we took:

We cancelled the providers registration.