New Century Care (Colchester) Limited

The Oaks 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?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this unannounced, comprehensive inspection on the 15 June 2016 to check that the provider had made the improvements required following our inspection on 16 December 2015.

During our inspection in December 2015 we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was placed into Special Measures and we imposed a condition on their registration to not admit any further people into the service. We told the provider to take urgent action to address and improve staffing levels, medicine management, infection control practices, cleanliness and hygiene, governance and management systems. We received an action plan from the provider and we have kept the service under review, with the expectation that significant improvement to have been made within a six month timeframe.

Despite assurances given by the provider and management following our previous inspection, at this inspection we found that robust and sustainable audit and monitoring systems were still not in place to ensure that the quality of care was consistently assessed, monitored and improved. The provider had failed to recognise and identify significant failings impacting on the quality of service provision, and risks to people.

The Oaks Care Home provides care for up to 61 people who are elderly and frail with complex needs that may include nursing and/or dementia related needs. On the day of our inspection there were 32 people living at the service.

There was a registered manager in post. 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.

The overall governance and oversight was not robust enough to ensure that all areas of the service were working well and improving. Where actions had been taken to improve there was no effective system in place to ensure those actions were being implemented and sustained. People continued to be at risk of infection, poor moving and handling, poor pressure relieving management and poor record keeping. Staff did not have the resources, including effective training, to support them to provide high quality care.

Care was not personalised and delivered in a planned and consistent way. The needs of people living with dementia were not considered and staff were not aware or understood how dementia affected those individuals in their day to day living. Staff had also not had training to help them understand other health needs of people for example, diabetes.

We found that there continued to be poor standards of cleanliness and infection control. The kitchen and kitchen equipment were unclean and unhygienic, and people were at risk from the unsafe management of

food.

Recruitment processes were not robust and operated effectively to ensure newly recruited staff were suitable for the role.

Since our last inspection action had been taken to address significant shortfalls in medicine management however further improvement was needed to ensure people received their prescribed medicines at the right time and ensure the correct period of time between doses.

There was a lack of oversight from all levels of management and quality assurance systems were not effective. This meant improvements identified in their action plan were either not being properly implemented or sustained. Resulting in continued non-compliance with regulations and poor outcomes for people.

This is the second time the service has been found to be Inadequate overall and continues to be in Special Measures, The Commission is considering its enforcement powers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from the risks associated with the unsafe management of food and ineffective cleaning regimes in the kitchen.

Records in place to protect people from the risk of developing pressure ulcers, infection and moving and handling errors were incomplete and unfit for purpose.

Recruitment records showed that appropriate checks had not been made on new staff before they were allowed to work in the service.

Improvements were seen in the way that medicines were stored, recorded, administered and monitored but people did not always receive their medicines at the correct time due to the length of the medicines round.

Is the service effective?

Inadequate

The service was not effective.

Staff understanding relating to the care of people living with dementia was inconsistent.

There was no evidence of training in regard to specific medical conditions to assist staff in the delivery of safe and effective care.

Changes in people's recommended fluid intake had not been recorded appropriately or implemented.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Little importance had been placed on meeting the needs of people living with dementia and there was a lack of care planning for meeting their needs.

Although staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans had been reviewed and updated monthly by the care team however there is further work required to develop more person centred care planning.

There were examples in the care plans reviewed where documents remained mainly task focused and not personalised or centred on the individual's needs, wishes and choice.

There was a lack of general activity throughout the day to ensure people's whole well-being. People were in their own bedroom for the majority of the day and only met together for meals or planned activities.

People and their relatives were given the opportunity to make comments about their care but concerns and complaints were not always responded to in a timely manner.

Is the service well-led?

Inadequate

The service was not well-led.

Robust and sustainable audit and monitoring systems were not in place to ensure that the quality of care was consistently assessed, monitored and improved.

The provider had failed to follow their own action plan and had been unable to demonstrate how they planned to sustain the improvements which had been made without adequate monitoring and oversight from all levels of management within the organisation.

The Oaks Care 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 unannounced inspection took place on 15 June 2016. The inspection team was made up of three inspectors, including a pharmacy inspector, a specialist advisor 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. The specialist advisor had knowledge and experience in acute nursing.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the registered manager, the clinical lead, the quality support manager and the chief operating officer. We also spoke with nine other members of care, housekeeping and kitchen staff.

We spoke with 11 people who used the service, three relatives, a visitor and two health care professionals who visit the service. We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care and support needs were being met we reviewed eight people's care records and other information, for example their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included

recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection on 16 December 2015 we found breaches in regulation about how the provider was protecting people against the risk of unsafe care. We found that people's safety had been compromised in a number of areas. This included the management of people's medicines, the monitoring of people at risk of and support for people with pressure ulcers, care and support for people with indwelling catheters and monitoring and support for people with their food and fluid intake. Staffing levels were insufficient to meet the needs of people who used the service. We asked the provider to inform us immediately of the urgent actions they would take with immediate effect to protect people and raise standards. The action plan received from the provider showed that all actions would be completed by April 2016. However, at this inspection we found that people continued to be at risk of harm.

People were not protected from the risks associated with the unsafe management of food and ineffective cleaning systems. In the kitchen we found ingrained dirt and a build-up of food debris, dust and grease on the floor, appliances and storage. The kitchen cleaning records for June 2016 were incomplete and did not demonstrate kitchen cleaning jobs had been completed on a daily basis. The cook was unable to tell us when the cookers had last been cleaned. Dried goods were found to be out of date and open jars were inappropriately stored to ensure they would be safe to eat. Effective maintenance or replacement of old and broken equipment had not been carried out to enable proper cleaning. For example trays to serve food were cracked and worn allowing for dirt and bacteria to collect.

Older people are more susceptible to infection and therefore we were concerned that the systems in place were not protecting them adequately. As a result we made a referral to the local authority environmental health team

In response to the issues found the registered manager and chief operating officer told us they would take immediate action to arrange for the kitchen to be cleaned that evening.

We saw other examples where staff were not following safe hygiene practice which exposed people to the risk of cross infection. This included two soiled blankets still in use on a person's bed which had not been removed for cleaning.

At our last inspection we identified concerns in relation to unsafe catheter care. The provider's action plan stated they would ensure people's catheter bags were emptied regularly to prevent discomfort and risk of infection. We found for the two people who required catheter care this was still not being carried out effectively, placing them at risk of infection.

Processes for ensuring people were moved correctly were also not robust or safe. People's moving and handling risk assessments and care plans did not always specify the control measures in place such as the type of hoist and the type and size of hoisting sling required in relation to their daily activities. Without accurate information for staff this potentially placed people at risk of serious injury if the wrong equipment was used.

In their action plan, the provider told us that pressure ulcer prevention for people at risk would be improved by ensuring they were repositioned regularly. Risk assessment plans and repositioning charts for people who were assessed at a high risk of developing pressure ulcers were not specific about how frequently they were to be repositioned to relieve their pressure. Without this information being clear they were at potential risk of skin breakdown because they could be left for prolonged periods without moving.

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

Recruitment processes were not sufficiently robust to protect people from staff that may not be suitable for the role. Records for two newly recruited staff did not contain necessary and relevant information required, including lack of assessment, to assure the provider of their suitability for the role, and caring for vulnerable adults.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had increased clinical staffing levels there was insufficient kitchen staff to ensure the kitchen was well managed, clean and hygienic. The kitchen cleaning schedules stated that cleaning had not been done due to having no kitchen assistant. The cook confirmed this as being correct.

People still felt that staff were often too busy to respond to their needs in a timely manner. One person said, "The staff can be busy and not always come when I call them." Another person commented, "Sometimes staff take a long time when I call and they may be busy."

Nursing staff were not deployed effectively across the service to ensure people received their medicines at the correct prescribed time. During this inspection the length of the morning medicine round was excessive, as the round continued people were receiving their medicines later than the prescribed time. If they received their next dose at the prescribed time it would have been too soon. This meant that people were at risk of not receiving their medicines at the correct intervals and times prescribed which could have put seriously detrimental to their health.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we saw improvements in medicines administration records. We observed that staff followed safe procedures at the time they gave people their medicines although people may not have always received them at the correct time.

Further improvement was required in the information available to staff relating to medicines prescribed to be given on a when required basis. This included pain relief strategies using more than one painkilling medicine. These improvements were necessary to ensure that staff administered these types of medicines consistently and appropriately.

Staff were aware of their responsibilities with regard to safeguarding people from abuse and knew how to report concerns. However, they did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

Inadequate

Is the service effective?

Our findings

New staff training and development programmes were in progress but had not yet been fully implemented. Plans were shared with us. However, training was not yet sufficient in some areas to show that people's healthcare conditions were fully understood by staff so their needs were recognised and met consistently.

There was a lack of awareness and understanding with regards to supporting people living with dementia. Care staff were unable to identify people who were living with dementia; they did not know about different types of dementia and how dementia may, or was affecting a particular person and how to meet their specific needs.

The majority of staff training was delivered via e-learning. One member of staff confirmed, "A lot of the training is e-learning, I prefer face to face training." The registered manager told us that workshops had taken place in key topics such as dementia awareness, nutrition and the Mental Capacity Act. The training plan showed that face to face dementia training took place every three years for care and nursing staff. Domestic, kitchen and administration staff had not yet received training in this area although there were plans for this to take place. However, discussions with care staff showed a lack of understanding relating to the impact and progression of dementia on a person. There was no strategy in place to ensure staff were aware of the latest guidance relating to dementia care. For example for kitchen or housekeeping staff to understand how food, drinks and meals could be provided in a way which would encourage people to eat and make it a pleasurable experience for them. As a result there was a lack of awareness of how best to assist people living with dementia to ensure their whole well-being in the provision of care and supporting services. We were concerned there was no clear link between the range of needs people had, the training all staff received and the quality of care they were able to deliver. For example, the staff cared for people with epilepsy and diabetes but they had not received training about these subjects to enable them to recognise and meet those people's needs more effectively.

Staff did not have a personalised development plan which reflected professional development or specialisms linked to the needs of people they cared for This meant that staff had not been equipped with the knowledge they needed to support people with these conditions safely and consistently.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the food provided was not always suitable for their needs. One person told us, "The food is not always suitable for people like me who are diabetic. They just give you whatever." Food was not always provided in a form that people could easily eat. For example, people told us that they were unable to eat the fruit offered from the fruit bowl because it was too hard. This showed a lack of awareness of how to provide food in a way which encouraged people and was accessible for people.

A new four weekly menu had recently been put into place. There were mixed views about the food. One person was not happy about the meal they had received that day, "Toad in the hole where the sausages was

cremated and I had a choice of ice cream or yogurt, I am not a child." However, another person said the meals were, "Better than they had been previously." People felt the timing of the meals were not appropriate. One person said, "Tea is served at 4:30pm. This is too soon after you have finished your lunch at 2pm and then they serve you supper at 6pm." This demonstrated that people's views regarding when they would like to receive their meals had not been considered.

Records used to calculate people's daily intake of fluid had not been sufficiently monitored as stated in the provider's action plan. Some people were at risk of dehydration and poor skin conditions. As a result staff needed to monitor their intake of fluid to ensure they had enough and were protected from those risks. Changes in people's recommended fluid intake had not been recorded appropriately so staff could not demonstrate that people were receiving the appropriate amount of fluids recommended by a dietitian.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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. Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decision for living in residential care. A recent care file audit highlighted that although mental capacity assessments were in place relating to DoLS they were not supported by a best interest decision record. The care file audit recorded that, "This is currently work in progress." The registered manager confirmed this but was unable to demonstrate when this would be completed.

Since our previous inspection a significant amount of input had been received from relevant health care professional with the aim of improving the service. One healthcare professional told us, "We have held a meeting, and plan to continue to do so, to discuss all residential patients…we have found this to be a very positive move forward." Another healthcare professional told us, "Since they had their inspection [December 2015] I have noticed that they have improved on some things but I think there is still a long way to go." New systems had been introduced to improve communication with healthcare professionals and needed to be built on for consistency to ensure safe and effective care.

Requires Improvement

Is the service caring?

Our findings

The providers website states, "All of our staff have a true interest in all our residents and have all the training expected of them." Whilst we saw some staff did show real interest and consideration, this was not consistent across the whole service. Although staff were seen to be caring and sensitive in their approach. The provider relied on this intuitive care and had not encouraged a culture to support these efforts alongside appropriate knowledge and resources, to help staff to understand the needs of people and how they should be cared for. For example One person who had difficulties with their speech told us they felt that some staff did not want to spend the time trying to understand them. Therefore they said they felt that they were often ignored. Staff did not understand the reasons people became anxious or upset. They described one person in a care plans as 'confused and unpredictable' with no exploration of why that might be the case, triggers that might make it worse, or ideas about how to distract or engage positively with them. Without this understanding staff were unable to provide person centred care with a holistic approach to ensure people's whole well-being

Since our last inspection care plans had been updated but they remained mainly task focused. They were not personalised or centred on individual's needs, wishes, choices and preferences about how people wished their care to be delivered and how they chose to live their daily lives. For example, one care plan in relation to assessing a person's personal care needs recorded, "They should receive a shower or bed wash daily," or, "needs a bed bath once a week." The care plan did not demonstrate that the person had been involved in this decision.

The management team told us that people's primary needs were nursing. No staff, including the registered manager, could tell us which of the people using the service were also living with dementia. On daily handover sheets people were referred to as having "Senile dementia." This is an outdated term that was previously used when it was thought that memory loss and confusion was a normal part of ageing, rather than being caused by specific diseases like Alzheimer's. This meant that the service was not considering the whole person when they were providing care, They had not considered the impact that having dementia related needs may have on the delivery of care and treatment. We were provided with examples where staff had been seen to have a general lack of respect for people and this led to poor culture within the service. For example a healthcare professional told us, "Patient privacy does concern me as when I am in a patient's room doing dressings, even if it's just legs, I always close the door and staff who are collecting cups etc. will just walk into the room, I feel there is no dignity for patients privacy."

In another example relatives had felt the need to remind staff about elements of people's care which were important to keep them comfortable. For example one had written a note they had placed in a person's drawer reminding staff to us the pop socks provided as the person's skin was delicate and prone to tearing. They were frustrated that the note was sometimes moved and care staff were not doing what was requested to ensure the person's comfort.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found that improvements were needed to ensure that care plans reflected all of people's current physical, psychological an emotional needs. The provider's action plan told us that work would be completed on this by the end of February 2016. At this inspection whilst significant work had been done, staff were not using them to support their delivery of care. For example, "This is Me" documents in peoples care plan documents aimed to give staff some details of people's history and things which were of importance to them. However, signature sheets at the front of each care plan for staff to sign to confirm they had read them were blank. Staff told us that these documents were kept in an office which was not easily accessible and they didn't have the time to read them. This meant that they did not have sight of this important information to help them understand people's needs and assist them to deliver person centred care. As a result staff lacked knowledge about people's individual health and care needs. For example staff could not identify people who needed catheter care and were unable to tell us about how dementia impacted on the way they provided people's care.

There was a lack of care planning for meeting the specific needs of people living with dementia. The initial assessment for one person showed they had been diagnosed with vascular dementia. However, there was no mention of the fact the person was living with dementia throughout the rest of their care plan. No details were given to alert staff to any potential triggers which could upset the person or guidance as to how they could support the person at these times. Without the appropriate knowledge staff were unable to provide person centred care with a holistic approach to ensure people's whole well-being.

One person's care plan contained some details of how to manage their diabetes. However it did not contain key information about what the person's blood sugar levels should be and what to do if they were too high. We were concerned that staff would not recognise the need to take action in order to prevent the person becoming seriously unwell. Without the appropriate knowledge about people's physical and mental health conditions staff were unable to provide people with the support and understanding required to ensure they were delivering a high standard of care which met all of people's needs.

We observed that people were in their own bedrooms for the majority of the day and only met together for meals or planned activities. Records showed a relative's concern because a person had not been assisted out of their bedroom into the communal areas. Staff told us that some people did visit each other in their own bedrooms but there was limited space easily accessible for people to meet more informally elsewhere. On the day of our inspection one of the lounges was being used by staff who were meeting with a training assessor, and another lounge was situated in the part of the building currently not being used due to refurbishment. Although this was available to be used if people wished, it was at the end of a long corridor and very isolated. This meant that people's opportunity for social interaction had been reduced and put them at potential risk of isolation.

The activities coordinator had adapted activities to suit people's needs but they had limited resources to assist in the delivery of meaningful activities throughout the day for people who were living with dementia. For example, reminiscence activities or the use of familiar daily tasks to encourage physical and mental

stimulation.

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

People and their relatives were given the opportunity to make comments about their care in meetings which had been held since our last inspection. The service is in the process of being refurbished and there was a display in the reception area giving people details about the project and asking for people's opinion. There was also a suggestion box in reception for people to use if they wished. There was a comments and suggestions book in the dining room which contained two entries; "I felt that honey on toast was inadequate" and "Fish today had little flavour." The book did not contain any action taken in response to people's feedback and staff were unable to demonstrate whether these matters had been discussed with people or addressed.

People could not be confident that concerns and complaints were acknowledged, listened to, appropriate steps taken to respond and opportunities taken to put things right.
Concerns and complaints were not always responded to in a timely manner and learned from to avoid reoccurrence. For example, a relative had needed to email a second time because the family had not received a response the first time a concern had been raised.

Relatives told us about problems they had experienced relating to people's hearing aids which had been lost. They told us that they had great difficulty in getting anything done about this. The losses had been reported and they had been assured by the registered manager that action would be taken to investigate and resolve the situations. However, relatives were unaware that any action had taken place.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were generally responsive to their calls for assistance, Although one person added, "When and if they have the time." We observed that most people were wearing pendant alarms to enable them to call for assistance wherever they were in the service. A healthcare professional commented, "The patient's buzzers do not seem to go off as long as they used to, as they would be going off for quite a while yet the staff would be standing doing nothing, this has improved."

One person pointed out that there were currently fewer people living in the service than normal and was concerned whether, if the ratio of people and staff changed again, the waiting times would return to their former level.

Inadequate

Is the service well-led?

Our findings

Despite assurances and an action plan stating that improvements would be made following our inspection in December 2015, there continued to be widespread and significant shortfalls in the way the service was led. There was a lack of managerial oversight at all levels and leadership was not pro-active. There was a failure to recognise and identify significant failings impacting on the quality of service provision.

Following our last inspection, the providers had produced an action plan to address the significant number of concerns raised. The service has been provided with a considerable amount of external support over the last six months from the local authority quality improvement team, community nursing teams and other health care agencies. Internal support to achieve the improvements stated in the action plan had been provided by an area manager and quality support manager. However, their audits had failed to identify concerns and input had not been sufficient enough to ensure a suitable and effective monitoring system was now in place to assess, monitor and identify risk and improve quality. Without this oversight the provider had failed to ensure that improvements had been embedded and sustained and that future shortfalls would be identified, appropriate action taken and lessons learnt.

The file containing record of audits showed that monitoring had been inconsistent and information we gathered showed them to be ineffective and failing to identify areas of concern. We discussed this with the registered manager and quality support manager who told us that the provider had recognised the structure of their monitoring system to be unrealistic and unachievable. Work was in progress to revise the quality assurance processes in all of the provider's services to enable senior staff to effectively implement and sustain an effective system which would identify shortfalls and assist them in making any improvements necessary. A representative from the provider was unable to tell us what the expectations were in terms of current management audits and how they were used to improve the quality. It was therefore unclear how the provider planned to ensure that risks to people would be mitigated in the interim period.

The audits which had taken place had not been monitored by the provider. They had therefore missed opportunities to put systems in place to protect service users from the risk of receiving inconsistent, inappropriate or unsafe care that did not meet their needs.

The provider's action plan stated that "daily" flash meetings were being held by the registered manager with heads of department to highlight people with changes in need and to inform work for the day. However these were only recorded as being held seven times in April, 11 times in May and four times so far in June. Staff told us that these meetings took place a few times a week which demonstrated that this new approach to improve quality of care was inconsistent.

An independent 'mock inspection,' commissioned by the provider had been carried out on 10 and 11 May 2016. This highlighted that wound care records were not always clear about the treatment to be provided. It had also found that care plans had not been updated with advice given by dietitians in relation to people's nutritional needs.

The 'mock inspection' report stated that all of the findings were discussed and detailed feedback given to the registered manager during the visit. Despite this, appropriate action had still not been taken to address the concerns raised when we inspected five weeks later. Therefore, this had been ineffective to trigger improvements needed to provide safe and good quality care to people.

Shortfalls in care records had not been identified in an audit undertaken by the registered manager and quality support manager. Fluid charts had not been monitored as stated in the provider's action plan. None of the management audits had identified the unhygienic condition and lack of effective cleaning regimes in the kitchen. Shortfalls with recruitment checks had not been identified by the management team during the recruitment process or in audit.

Although people and staff told us that there had been improvements in the service and a member of staff told us they were, "Pulling together more," there was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met.

The lack of oversight from all levels of management meant improvements were either not being properly implemented, monitored or sustained. This resulted in continued non-compliance with regulations and poor outcomes for people.

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