

Angels (Kingsleigh) Ltd

Kingsleigh Residential

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Kingsleigh Residential is a residential care home providing personal care for up to 23 people. The service provides support to older people. At the time of our inspection there were 17 people using the service.

Kingsleigh Residential is a large detached property. There is a communal lounge and dining area on the ground floor. Bedrooms are on the ground and first floor.

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

An overall service improvement plan had not been completed. Therefore, whilst some improvements had been made, we identified shortfalls in the oversight of the premises and risks to people. Governance systems were still not full effective in identifying actions required and driving quality and safety improvements.

The provider had not ensured the systems and culture within the service drove high standards of care to ensure people were well treated and supported. People, relatives and staff did not have opportunities to give feedback about the service and be engaged in the development of the service.

Training records had been improved and were now organised. Staff received training and ongoing supervision to be skilled in their role. New staff received an induction.

People were supported by staff who were kind and caring. Staff knew people and their preferences well. Changes in staffing meant there was mixed feedback received about staffing levels and how this impacted on care delivery.

People enjoyed the food provided and enjoyed a social dining experience. People's health needs were met. The service worked in partnership with other professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update

The last rating for this service was inadequate (published 06 August 2021) where breaches of Regulation 12, 15 and 17 were identified. A recommendation was made in relation to staff training records. Following the inspection published 06 August 2021, the provider was placed in special measures. After the inspection, published 06 August 2021, two warning notices were issued for regulation 12 and 17. These were followed up in a targeted inspection (published 04 October 2021).

At this inspection we found the provider remained in breach of regulations 12, 15 and 17.

At our last inspection we recommended the provider reviewed current guidance around the recording and organisation of staff training. Improvements had been made and the provider had met this recommendation.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection. For the key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed to requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to 12 (Safe Care and Treatment), 15 (Premises) and 17 (Good Governance).

We have made two recommendations in relation to medicines and capacity assessments.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate ●

Kingsleigh Residential

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 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

Kingsleigh Residential is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Kingsleigh Residential 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 reviewed information we had received about the service. 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 used all this information to plan our inspection.

During the inspection

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

We spoke with ten staff members which included the registered manager. We spoke with four people that use the service, twelve relatives and two health and social professionals. We reviewed seven people's care records and eleven medicine records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies, procedures and audits were reviewed.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At the last comprehensive inspection conducted in June 2021 we identified the provider had failed to ensure a safe and well maintained environment. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection whilst there were some improvements, not enough had been made and the provider was still in breach of Regulation 15.

- The legionella risk assessment produced in September 2021 had not been reviewed to ensure all recommendations had been actioned.
- Room checks had been completed to identify required maintenance. However, this had not resulted in the information being communicated to ensure work was undertaken promptly. Therefore, we found a window which had a crack and needed replacement and broken handles on windows meaning people could not regulate the temperature of their room.
- Feedback we received indicated further improvements and refurbishments were needed. One relative said, "The room is basic with a bed and chair, there is also a wobbly side table." Another relative said, "The décor is not the best."
- The action plan around the premises was not detailed of work required or kept updated to monitor progress. For example, around required fire actions which included the replacement and installation of several fire doors.

This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Regular checks were now undertaken in electrical, gas, water and fire safety.
- Some environmental improvements had been undertaken. Flooring had been replaced to ensure it was safe for people. Redecoration had occurred in parts of the service and was ongoing. Furniture and equipment highlighted at the last inspection had been replaced.
- Risks had not always been identified and assessed where required for people. For example, we found assessments were not in place for one person who had returned from hospital and had sustained an injury, another person who had been involved in a sexual safety incident and two people with known health conditions.
- We found a room containing the boilers open on three occasions which had hot pipes. Signage indicated

this room should be locked at all times.

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

- A business continuity plan gave directions in the event of unforeseen events such as floods, staff shortages and IT failures. People had personal evacuation plans which demonstrated the support people required in an emergency.

Using medicines safely

- Medicines Administration Records (MARs) were not always signed or countersigned when handwritten.
- Protocols for as required medicines were not in place for two people reviewed. This meant that the medicine may not be given when the person demonstrated it was needed.

We recommend the provider ensures current guidance is followed for handwritten MARs and as required protocols.

- Medicines were ordered and disposed of safely. Regular stock checks were undertaken. Temperature of medicines storage areas were completed. A relative said, "The staff give [Name of relative] their tablets."
- Medicine audits were completed. This had identified some gaps in topical medicine administration records which had been highlighted to staff.

Preventing and controlling infection

At the last comprehensive inspection conducted in June 2021 we identified the provider had failed to ensure people were protected from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was issued and was met when reviewed in a targeted inspection in October 2021.

At this inspection improvements had been made and the provider was no longer in breach of Regulation 12, in relation to the risk of infection to people.

- We received mixed feedback about the cleanliness of the service. One relative said, "The home is always spotlessly clean and tidy." One person said, "All the time they [staff] are cleaning." Another relative said, "The home is not terribly clean. I really feel that I have to watch where I sit when I am there." Areas we observed to be unclean in the morning were attended to in a timely manner.
- We observed regular cleaning being undertaken of communal areas, bathrooms and people's rooms. Cleaning schedules were completed. However, these had not been monitored by senior staff to ensure cleaning was undertaken as directed.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely. A relative said, "The staff wear gloves and masks at the moment."
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

- We were assured that the provider's infection prevention and control policy was up to date.

The provider was facilitating visiting in line with government guidance. A visiting procedure was in place.

Staffing and recruitment

- We reviewed the staffing rotas which showed staffing was kept at the level deemed safe by the provider. A staffing dependency tool was used to determine staff numbers based on people's assessed need. Where we identified people's risk assessments had not been updated or completed this may have affected people's assessed support needs.
- The provider acknowledged recruitment challenges in filling current staff vacancies. There had been a recent turnover of staff. Vacant shifts were filled by agency staff, some of whom knew the service well.
- We observed staff to be available and attentive to people's needs. However, staff were busy. We received mixed feedback around staffing. A relative said, "There always seems to be plenty of staff around." Another relative said, "The home runs on bank and agency staff, people I have never seen, they seem good, but it is not the same." A staff member said, "Staffing is poor. We are losing good carers."
- Recruitment processes were followed. This included obtaining references on previous employment and a Disclosure and Barring Service check (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- We found two staff did not have an interview record and one staff member's gap in employment had not been followed up. There were no checks on recruitment files to ensure all stages of the recruitment process had been fully completed.

Systems and processes to safeguard people from the risk of abuse

- Staff had received training in safeguarding adults and knew how to identify and report concerns. A relative said, "[Name of family member] says they feel safe at Kingsleigh Residential because there is someone there twenty-four hours to care for them." Another relative said, "I feel that [Name of person] is safe because they are well cared for and happy."
- Identified safeguarding concerns had been reported to the local authority and CQC as required.
- There was a brief safeguarding overview. However, investigatory information was not held together to enable the registered manager to track findings and outcomes of safeguarding concerns.

Learning lessons when things go wrong

- Accidents and incidents were reported and recorded. This detailed action taken and any learning for each incident. Records showed staff took appropriate action in response to accidents and incidents. For example, calling emergency services when one person was unresponsive.
- However, there was no overview of accidents and incidents to monitor frequency and times for individuals. This meant that the registered manager was unable to monitor an increase of incidents or accidents for individuals and if actions taken to prevent a reoccurrence were effective.
- Staff told us they were informed through internal communication systems when things had gone wrong and lessons were learnt. One staff member said, "We get a chance to reflect on things like accidents and safeguarding's."

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 requires improvement. At this inspection the rating has changed to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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 assumed to have capacity unless an assessment had been carried out to determine they lacked capacity for a specific decision. Assessments conducted were clear and best interest decisions showed the agreed outcome. For example, people had assessments to determine if staff should administer medicines in their best interests.
- However, we found one person who was deemed to have capacity who had been stating since our last inspection they wished to leave. Actions were not documented to demonstrate how the service was facilitating this. For another person who had a diagnosis of dementia, records did not show what areas their capacity had been considered in.

We recommend the provider considers current guidance and reviews capacity assessments where required.

- DoLS had been applied for where appropriate. The registered manager had an overview of applications.

Staff support: induction, training, skills and experience

- Staff had not completed the Care Certificate where appropriate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. The registered manager said this was currently being set up.

- Staff now received a structured induction when commencing employment. A staff member said, "I reviewed paperwork, did a tour of the home and shadowed staff."
- At the last comprehensive inspection in June 2021 a recommendation was made for the provider to review current guidance on staff training and how to record completion of any training undertaken as training records were of poor quality.
- At this inspection training records were organised well. Staff had undertaken a range of training relevant to their role. Staff we spoke with confirmed the training they had completed. For example, in manual handling, fire safety and safeguarding.
- Regular supervisions took place with a senior staff member. One staff member said, "Yes, I have supervisions."

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

- We have referred further to the design and decoration of the service in the safe area of this report.
- People had their own personal items in their rooms. One person said, "I like my room, it's my own little area."
- There was a well maintained front garden. People would need support to access the garden safely.
- There were handrails to support people moving around the service, which we observed people using. Different colours had been used to distinguish areas for people. There was written and pictorial signage to orientate people within the home.

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

- People were supported with their nutrition and hydration. People had a nutritional care plan in place which expressed their preferences. One person said, "The food is nice."
- People enjoyed a positive and social dining experience. People were shown food options to enable them to choose their meals. Staff were attentive to people's support needs in a discreet manner.
- People's weights were monitored. There was access to regular hot and cold drinks and snacks. A relative said, "[Name of person] says they enjoy the food and there is a good choice."
- Kitchen staff knew people well and engaged with them. People were consulted about what they would like and alternatives offered where appropriate. People's dietary needs and preferences were supported. A relative said, "The chef will come and ask [Name of person] what they would like for lunch, they will go out of their way to find something they like."

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

- The service worked with other professionals to access additional health care when required, such as district nurses, GPs and the chiropodist. A relative said, "[Name of person] had a fall when they were in their room, the staff got the doctor out."
- The service took advice where required. A health and social care professional said, "Staff have acted on everything I've suggested." One person said, "I like it here. I am nice and comfortable."

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

- Staff we spoke to understood how to reflect the principles of the MCA in their practice. We observed staff offering people choices. For example, on what they would like to eat. A health and social care professional said, "From what I've seen staff understand MCA and capacity."
- The service facilitated advocates for people. This enabled people to have independent support.

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider had not ensured the systems and culture within the service drove high standards of quality care to ensure people were well treated and supported.
- The provider had not ensured people's well-being and safety was paramount due to continued shortfalls found.
- People's protected characteristics under the Equality Act 2010 had not been fully considered in people's care plans. For example, around people's culture, religion or sexuality.
- Feedback we received described how staffing impacted on care delivery. A health and social care professional said, "It is just basic care and there aren't enough staff." A relative said, "The carers are kind and caring, but there is just not enough of them, they will apologise and say that they have not had time to do things."
- People were supported by staff who were caring. One person said, "The staff are nice." A relative said, "I find the staff very nice, they are really lovely and friendly." Another relative said, "The staff seem quite nice, pleasant, and welcoming. The home seems a happy place and I have never seen any of the residents looking unhappy."

Supporting people to express their views and be involved in making decisions about their care

- People's family members had not always been involved in care reviews. One relative said, "There is not a lot of discussion about the care, If I want an update, I have to track someone down when I visit. There is never anything detailed. Another relative said, "I have power of attorney and should be involved in [Name of person's] care plan, but I do not get contacted at all unless there is an issue. I have no idea, for example if or how [Name of person] is stimulated."
- People's care plans reflected their preferences and wishes. For example, one care plan said, "Likes to choose their clothes each day. Likes to look nice and wear colourful clothes."
- People's relatives or close friends had contributed to a document on admission which described the person's personality, hobbies, interests and important relationships. This meant that staff had key information about what was significant to people.

Respecting and promoting people's privacy, dignity and independence

- People were treated with respect. Observations showed staff spoke to people in a caring way. A health and social professional said, "I've witnessed staff being great with [Name of person]. Staff I've seen are very calm and gentle."
- We observed staff protecting people's dignity. For example, one person was helped to change as their

clothing was ill fitting and compromising their dignity.

- People's privacy was respected. We observed staff knocking on people's doors and waiting to be invited in. Staff knew how to ensure people's privacy was upheld during personal care.
- Care plans described how to support people to maintain their independence. We observed staff supporting people in a relaxed and measured way to enable their independence. For example, when supporting people to mobilise around the service.

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 inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last two comprehensive inspections in June 2019 and June 2021 the provider had failed to operate effective governance systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was issued and we checked this had been met at the targeted inspection in October 2021.

However, at this inspection not enough improvements had been made and the provider was still in breach of Regulation 17.

- Some improvements had been made in governance systems since the last inspection. However, they were still not fully effective in identifying shortfalls and driving quality improvement. The provider and registered manager did not use the governance systems to have full oversight of the service. We found repeated breaches in regulation.
- There were no checks completed on staff recruitment files. Care file audits did not identify where information was lacking.
- There was no service improvement plan to monitor previous shortfalls in standards and breaches in regulation. Therefore, sufficient actions had not been taken to develop the service. An action plan had been completed around Regulation 15 (Premises). However, the plan did not detail work required or monitor progress sufficiently. For example, actions taken in relation to the legionella risk assessment recommendations and requirements made by the fire service. Room checks conducted did not ensure identified work was completed promptly.
- The provider information return (PIR) gave limited information. This did not demonstrate the service was developing to deliver high quality care.
- Safeguarding information was not held together. This meant investigation findings and actions taken to keep people safe could not be fully demonstrated.
- Accidents and incidents were not analysed for patterns or trends and to ensure actions taken were effective.

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

- Notifications were submitted as required. A notification is information about an event or person which the

service is required to submit to CQC. Notifications help CQC to monitor services we regulate.

- The provider had displayed their CQC assessment rating at the service and on their website.

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

- We received mixed feedback about how the service was led and managed. Relatives commented, "The registered manager is very good and keeps me informed," and "The registered manager can be difficult to get hold of." Staff said, "The registered manager is not leading by example or visible," and "The registered manager is approachable." A relative said, "I rang the night before last and asked to speak to who was in charge and was told that no one was in charge."
- There were limited assurances on the progress of improvements. Staff comments included, "The home is not moving where it needs to go," "The decoration has improved but not much else," and "We are evidencing better what we are doing. We have better handovers." A relative said issues raised were not always followed up.
- Staff said they worked well together. One staff member said, "We work well as a team." Another staff member said, "Staff are supportive of each other."

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

- People, relatives and staff were not engaged and involved in giving feedback about the service. This was raised at the previous inspection. A relative said, "I feel powerless to state my opinion, I have never received a survey." A staff member said, "I have never had a staff survey."
- Staff meetings had occurred. However, there were limited meetings with different departments or senior staff. The culture of the service needed improvement as staff morale was not high and staff were not always engaged with developing the service. One staff member said, "We need some enthusiasm into the staff team."
- Staff worked to create a happy atmosphere for people. One staff member said, "People feel really at home."
- The service conducted a 'resident of the day' system. Which aimed to gain people's experiences of different elements of their care.
- Communication systems were in place to ensure information was shared with staff. One staff member said, "We have a verbal and written handover."

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 registered manager understood their responsibilities under the duty of candour regulation.
- Relatives told us they were informed of any incidents or concerns. One relative said, "They [staff] informed me when I visited that [Name of person] had fallen." Another relative said, "Yes they ring me and notify me."

Working in partnership with others

- The service worked in partnership with health and social care professionals and advocates. A health and social care professional said, "They have asked for advice and have followed it up. They have acted on everything I've suggested."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises were sufficiently maintained. Regulation 15 (1)(e)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people were mitigated. Regulation 12 (1)(2)(a)(b)

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to monitor the safety and quality of the service. Regulation 17 (1)(2)(a)(b)

The enforcement action we took:

We imposed a condition on the provider's registration.