Living Ambitions Limited

Living Ambitions Limited - 231 Stafford Road

Inspection report

231 Stafford Road
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Living Ambitions Limited - 231 Stafford Road is a residential care home providing the regulated activity of accommodation and personal care to up to 6 people with a learning disability. At the time of our inspection there were 5 people using the service, one of whom was in hospital.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the Safe, Effective and Well-led key questions, the service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture.

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

Right support: The provider failed to ensure people had the right support. The care records guiding staff as to the support people required were inadequate. Risk assessments, needs assessments and support plans were missing. Those in place contained inaccuracies and were out of date. Short staffing meant that people were supported with a high level of agency staff use. The provider failed to provide agency staff with an induction. This meant agency staff did not know people's needs or preferences or how to support them.

Right care: Staff cared about the people they supported but were frustrated by their inability to deliver person centred care because of the provider's failings. People's care records were in disarray. People's weekly activity timetables did not accurately reflect what they did. This is because the timetables were out of date and there were not always enough staff available to support people to do the things they wanted to. Staff received training but they did not receive supervision or appraisal. Essential improvements were required to the home. For example, without the services specialist bath being repaired, one person had no choice in how their personal care was received other than to have a bed bath.

People were not supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests, but the provider's systems in the service did not support this practice.

Right culture: The provider failed to promote the right culture at the service. Staff were stressed and demoralised having been through a period when the service had no management at any level. This included the failure by the provider to ensure a manager, deputy manager, senior support worker, shift leaders or keyworkers were in place. Staff described the multiple safeguarding alerts raised during this period as "inevitable." Staff felt "abandoned" by the provider's leadership as they struggled to maintain the service

which was short staffed. This resulted in staff working many additional 14 hour shifts, with one member of staff working 300 hours in one month to protect people from the risk of neglect and the failure of the service to provide basic care and support. The provider's leadership failed to demonstrate the values and attitudes expected of them by people, their relatives, staff and healthcare professionals.

The provider had temporarily redeployed one deputy manager from another of its services to address the wide range of serious and immediate problems at the service. This inadequate level of response further demonstrated the provider's lack of urgency in ensuring people's safe care and treatment.

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 (published 18 August 2017).

Why we inspected
We received concerns in relation to safeguarding, management and staffing at the service. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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.

The overall rating for the service has changed from Good to Inadequate based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

After this inspection the provider forwarded us an action plan which stated the steps they will take to address the concerns that we found.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Living Ambitions Limited - 231 Stafford Road on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to people's safe care and treatment, staffing and the provider's leadership of the service.

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 have requested further action plans from 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 '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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Living Ambitions Limited - 231 Stafford Road

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
This inspection was undertaken by one inspector.

Service and service type
Living Ambitions Limited - 231 Stafford Road 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. Living Ambitions Limited - 231 Stafford Road 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 15 and ended on 23 November 2022. We visited the service on 15 and 18 November 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with 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
During the inspection we spoke with 2 people, three staff, the acting manager and the area manager. We received feedback from one relative and 3 healthcare professionals. We reviewed 4 people's care records and 3 staff files. We reviewed the environment of the service and checked health and fire safety, medicines, financial and quality assurance records.

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.

Assessing risk, safety monitoring and management

- People were not always protected from foreseeable harm. The provider failed to always assess and mitigate risks to people. We found that two people had no risk assessments relating to any aspect of the health, care or support. This meant staff did not have information about people's risks or what they should do to reduce them.
- People who were identified as being at risk of swallowing unsafely were not always safely supported. One healthcare professional told us there was poor practice around supporting people to eat and drink. Another healthcare professional told us they had asked for a coughing chart to be kept for one person, but despite a second request, this had not happened and was still not in place. Coughing charts are used to identify where people maybe swallowing unsafely and risk inhaling foods or liquids into their lungs. The provider's failure to monitor people's risk of aspirating meant healthcare professionals did not receive the important information they required to assess and plan around people's safety.
- The provider did not do everything that could be done to protect people from malnutrition. One healthcare professional told us that the charger for the service's weighing scales went missing and were not replaced. This meant the provider could not weigh people to monitor their weight or identify rapid weight loss which could indicate a person was not eating enough or the presence of a health concern.
- People were at risk of being supported unsafely. This was because the provider failed to develop care plans to guide staff on meeting their assessed needs. Two people did not have assessments or care plans. This meant the provider failed to do all that was necessary to protect people against avoidable harm because staff were not provided with sufficient information to do so.
- The provider failed to ensure that staff were prepared to respond safely to a fire incident. The service's fire alarm system was not tested weekly in line with the provider's fire policy and staff did not carry out fire drills during which the evacuation of the service should have been rehearsed. Whilst people had individual personal emergency evacuation plans in place these were not reviewed. This meant the provider could not be sure people would be kept safe in the event of a fire emergency.

The provider's failure to assess risks and to do all that is practicable to mitigate risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staffing and recruitment

- There were not enough staff to safely and effectively meet people's needs. One person told us that as a result, "Sometimes I can't go and do things." One member of staff told us, "Some activities can't happen without enough staff." One healthcare professional told us the service was short staffed most days. On both days of our inspection there were 3 staff on shift when there should have been 4. All of the staff we spoke

with told us they had the experience of working on shifts when there were only 2 staff rather than 4.
● One member of staff told us, "We had no management for two months or more. We were on own with no support at all." The issue of short staffing was particularly acute during this period. One member of staff member said, "We were abandoned and demoralised and some staff lost their discipline. Some stopped coming to work. They would cancel their shifts; not sick, they would just say they were not coming in. It was so stressful, and the senior managers did nothing." Another member of staff told us, "We had to work overtime because we care about the people." This meant people were supported by insufficient numbers of tired, stressed and unsupported staff.
● To manage the shortfall in staff the service was dependent on agency workers. However, agency staff did not have a clear understanding of people's needs, risks and preferences. This was because the provider failed to provide agency staff (along with redeployed permanent staff) with an induction. One member of staff told us, "I had no induction when I started. I didn't shadow anyone. I went straight to work and learned as I went along." Another member of staff told us, "We rely on bank and agency. But agency can't do much… they can't take someone out with epilepsy, and they can't be left here with them when we take someone else out."
● The provider's lack of a formal processes to familiarize agency staff with people's needs compounded the problems caused by incomplete and inaccurate care records. This meant people were at risk of receiving unsafe care because the provider failed to induct agency staff or ensure the care records guiding them were complete and accurate.

The provider's failure to deploy sufficient numbers of competent staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

● Prior to the arrival of the acting manager two weeks before our inspection, the provider had failed to oversee basic safety around access to people's money. For example, all staff (permanent, bank and agency) could access the keys to the service's safe within which people's monies were kept. In addition, the service did not operate a system of regular physical checks of people's cash or checks of financial transactions and receipts. When people's money went missing this was raised as a safeguarding alert and the police were informed of the theft. The provider reimbursed people for the amounts stolen.
● Following their recent arrival in the service, the acting manager took action to safeguard people from further financial abuse. Measures introduced included strictly restricting access to people's money, the purchase of a new safe, daily checks of people's physical cash and a daily audit of transactions. This meant people's risk of further financial abuse was reduced.

Preventing and controlling infection
●The provider failed to adequately protect people from the risk and spread of infection. During the infection we found two bins in the kitchen area were open and uncovered. Because bins in a food preparation area did not have lids, people were not appropriately protected from the spread of germs.
● Prior to our inspection the service's washing machine broke down. Staff took soiled laundry to and from another service to be washed. However, no risk assessments were in place to manage the risk of cross contamination. Whilst the acting manager had ordered a new washing machine the infection risks to people had not been identified or reduced.
● In response to the risks posed to people by COVID 19, providers are expected to follow published guidance to reduce risks and keep people safe. One measure providers are expected to follow is enhanced cleaning. This involves an increased attention to cleaning areas of the service where there are high levels of hand contact such as doors and handles. Not all of the staff we spoke with were aware of this requirement and said they were not following it.

The failure to prevent and control the risk and spread of infection is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

● Staff wore personal protective equipment appropriately.

Using medicines safely

● The provider failed to operate processes to ensure people's medicines were always managed safely. People's medicines were not audited. This meant there was a risk of medicines errors going undetected. At the time of our inspection the acting manager had created a new weekly and monthly auditing process for medicines. However, this process started the day before our inspection began so its effectiveness could not be determined.

● Not all staff were sufficiently trained to administer medicines to people. The acting manager was in the process of reviewing staff medicines training and competencies to ensure all were able and confident to administer medicines safely to people.

● There was excess of medicines at the service. This included several months' worth of liquid thickeners which should have been returned to the pharmacist. At the time of our inspection the acting manager was arranging for surplus medicines to be collected.

The provider's failure to operate proper and safe management of medicines is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

● The service had an incident form folder to record when people had sustained injuries. However, not all accidents and incidents were recorded in it. For example, health and social care professionals informed us about injuries sustained by people which were not recorded in incident logs. Indeed, there was only one entry for 2022. This failure to adequately record, track and analyse accidents and incidents meant the provider was unable to identify changes in people's risks or take action to reduce them.

● Staff were not confident about raising safeguarding concerns with the provider. One member of staff said, "When you complain over and over and nothing happens you give up and you become fearful of becoming a target. Up until the new area manager and new acting manager all my concerns were ignored."

● Staff were unsure about the provider's whistleblowing procedures. We explained to each member of staff that whistleblowing is a legally protected process whereby concerns regarding people's safety can be shared with social workers in the local authority or with the CQC. We provided contact details to staff who requested them.

The provider's failure to assess, monitor and mitigate risks relating to health and safety; and to maintain accurate and complete care records for people is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● The provider failed to ensure people had assessments and care plans in place to guide staff towards meeting people's needs. One healthcare professional told us there was a lack of records. Another healthcare professional relayed that the care plans on file were those written by the funding authorities, noting the service should have developed their own. We identified two people for whom the provider had not written needs assessments, care plans or support plans. This meant staff did not have information from the provider as to how care and support should be provided.
● Where people had care records in place these were out of date and in some cases contained inaccurate information. For example, one person's care record stated they could not use speech and had no communication needs. This contradicted the assessment undertaken by three health and social care professionals which stated the person could use limited speech and had high communication needs. This meant the person was at risk of not having the needs and preferences met because of the provider's inaccurate care records.

The provider's failure to maintain accurate and complete care records for people is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Supporting people to live healthier lives, access healthcare services and support; supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care.
● The absence of appropriate care records meant the provider was not doing all they could to ensure people led the healthiest lives they could.
● Where people had been identified with specific health needs, care was not always provided by staff in line with the specific, detailed guidelines set out by healthcare professionals. For example, one healthcare professional told us they observed staff offer puree food to one person which was too thick, despite having addressed this concern with the former registered manager and stating it in the person's Eating and Drinking Plan. This meant the provider failed to ensure that care and support was always delivered in line with guidance provided by healthcare specialists.
● People's health action plans and hospital passports were missing and out of date. Both of these care records contain important information about people. For example, hospital passports contain information about people's health needs, risks and communication. Where people had these care records they had not always sent with people, as intended, when they were admitted to hospital. One relative told us their family member had been admitted to hospital without their hospital passport. They said, "It is imperative to [family

member's] health that their drinks are thickened, and all their food puréed due to a risk of aspiration. I question how the hospital would know this without their hospital passport going with them as [family member] is unable to communicate their needs." This meant the provider failed to work appropriately and collaboratively with healthcare colleagues to ensure people received safe, effective and timely care.

The provider's failure to provide other agencies with the care records they require to provide safe care and treatment is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staff support: induction, training, skills and experience
● People were supported by staff who were not supervised. One member of staff said, "I haven't had supervision." Staff files showed that no one-to-one staff supervision meetings took place in 2022. This meant people received their care from staff who were not adequately supported.
● The provider failed to review the performance of staff. One member of staff told us, "I have never had an appraisal." Staff records showed they were not receiving annual appraisals. This meant people received their care and support from staff who did not have the quality of their work evaluated or a plan in place to support their improvement and development.

The provider's failure to ensure that staff received supervision and appraisal is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Adapting service, design, decoration to meet people's needs
● People were unable to use the service's specialist bath. Whilst most people could use the service's wet room to shower, the bathroom could not be used because neither the bath nor ceiling hoist worked. This meant that one person, who could not use the shower was unable to bath either and could only be supported with bed baths. The acting manager had an action plan to repair the bath and bring the bathroom back into use. We will be monitoring the successful completion of this task.
● The communal toilets in the service did not have toilet seats. This meant people were required to sit on cold and uncomfortable porcelain. We were informed that toilet seats had been removed to prevent people's fingers being trapped. We were not shown risk assessments supporting this decision. The acting manager told us they were liaising with occupational therapy to address this shortfall and ensure people were supported to use appropriately adapted toilets.

The provider's failure to ensure that all equipment was properly maintained is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

● The service was wheelchair accessible on the ground floor. People had access to communal areas including a dining area, lounge and kitchen as well as a garden that had recently been improved.

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 treated in line with legislation. We checked three people's records in relation to their mental capacity. One person was presumed to have capacity and two who lacked capacity had capacity assessments in place.

● Where people were subject to DoLS restrictions to keep them safe, the details of the restrictions, approved by health and social care professionals were in place. However, were DoLS restrictions were due for review and renewal it was not clear whether referrals had been made to the local authority by the care home's former registered manager. At the time of our inspection the acting manager was reviewing people's mental capacity assessments and best interest decisions and was making referrals to the local authority regarding people's DoLS.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- People received their care and support from stressed and demoralised staff. A healthcare professional told us the morale of staff was very low and believed this was due to the service not being well led and the lack of guidance for staff. One member of staff told us, "I want to leave. I'm extremely stressed with the way this place is going. We have been left by the people at the top to get on with things. We had no leadership at all. We are rudderless. I have only stayed because I am so concerned about what I've seen."
- The provider demonstrated failure in their oversight and management of the service. They failed to always ensure safe levels of competent staff during what one member of staff described as the, "Near complete collapse of the service" in the two months that followed the departure of the registered manger. Another staff member said, "It was a nightmare. Some staff weren't coming in, so other staff were working 300 hours a month in 14 hour shifts to try to keep things going. We were dead on our feet".
- Leadership failings and staff disorganisation meant that people were at risk of unsafe care. One member of staff told us, "We were freewheeling to disaster. All of the safeguarding [concerns] we had during that time were inevitable." One healthcare professional told us they had observed people whose personal hygiene needs had not been met and who were not supported to transfer and position in line with guidance. In addition to the provider's failure to oversee adequate leadership and governance at the service, they also failed to organise the staff team and to delegate roles and responsibilities appropriately. Examples of these failings included no members of staff being designated as shift leader with responsibilities for essential tasks such as people's medicines, care records and money. At the time of our inspection we found that medicines were over stocked, care records were in disarray and safeguarding alerts had been raised due to missing money and unsafe support.
- The provider's quality assurance processes failed to identify and improve a wide range of serious shortfalls. These included missing and inaccurate care records; short staffing managed by using agency staff who did not receive an induction; no fire drills; the service's only bath out of action; staff not receiving supervision; and a failure to carry out regular, important audits such as of people's medicines and finances. It was evident that the failings we found extended back many months before the service's registered manager left the service in September 2022. This meant the provider's quality assurance failings had been systematic, significant and consistent over time.
- The service did not have a registered manager or deputy manager in post. The acting manager for the service was a deputy manager from one of the providers other services in a separate city. The acting manager had been in the role for only two weeks at the time of our inspection. They were aware of the

problems we found and had developed an action plan.

The provider's failure to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

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 provider was not always open with people and their loved ones when things went wrong. One relative told us, "Within the last few months there have been 3 safeguarding issues. All came to my attention when I received a call from a social worker."

Continuous learning and improving care; Working in partnership with others

● Following our inspection, we requested an action plan from the provider. From their response it was not immediately apparent that the provider understood the gravity of the service's failings and the urgency to improve the quality of care people received so as to protect them from unsafe care and treatment. The problems at the service included multiple safeguarding investigations, inadequate care records, agency staff without induction; quality assurance failings, the failure to provide support in line with healthcare professionals instructions and an unsupervised and demoralised staff team. The provider had redeployed one deputy manager on a temporary basis without any immediate, additional on-site-management presence to provide support. We were concerned that the provider failed to recognise the seriousness of the problems at the service.

● Staff expressed support for the acting manager and the provider's new area manager. One member of staff told us, "I have seen more of the manager and area manager in the past fortnight than I have seen in the past year. I know they are experienced, but they are firefighting right now. We are in crisis." One healthcare professional told us that the the acting manager was aware of the challenges at the service and was addressing them as best they could. They viewed the acting manager as being more proactive and focused than the previous manager.

●Because so many care records were missing, inaccurate and out of date, the acting manager had an action plan to re-write people's care records and to re-refer to healthcare professionals. However, the need for staff to be guided by accurate care records was urgent and deserved of a more robust response by the provider.

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

● People were supported by a diverse team who were aware of people's cultural and spiritual needs. Staff recognised people as individuals with unique experiences, preferences and aspirations and were motivated to meet their needs in a person-centred way.

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's failure to ensure that all equipment was properly maintained is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment. Regulation 15 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider's failure to deploy sufficient numbers of suitably competent staff and to ensure that staff received supervision and appraisal is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. Regulation 18 (1) (2) (a)

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's failure to assess risks and to do all that is practicable to mitigate risks; prevent and control the risk and spread of infection and operate proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Regulation 12 (1) (2) (a) (b) (g)

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's failure to maintain accurate and complete care records for people and to maintain accurate and complete care records for people is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

Warning notice.