Blue Sky Care Limited

Richmond Lodge

Inspection report

off 35a Richmond Road
Kirkby-in-Ashfield
Nottingham
Nottinghamshire
NG17 7PR

Tel: 01623750620
Website: www.blueskycare.org

Date of inspection visit:
07 February 2023
09 February 2023
16 February 2023

Date of publication:
21 August 2023

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

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Richmond Lodge is residential care home providing personal care for up to 5 people with a learning disability. Accommodation is provided over two floors. A communal lounge, conservatory and dining kitchen are based on the ground floor. At the time of the inspection 4 people were living at the service.

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

Right Support
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Staff did not deliver care and support in line with people's needs and strengths. People's interests, abilities and strengths were not promoted to ensure they lived fulfilled lives. Lessons were not learnt to reduce the risk of repeated incidents.

Right Care
Staff did not always understand how to protect people from poor care, neglect and abuse. Staff completed safeguarding training but did not always recognise incidents as abuse. Individual risks were not always accurately assessed or managed well, and this placed people at risk of harm.

Right Culture
Support plans showed people had been involved in creating these however the provider failed to effectively monitor records to ensure care was delivered in line with their needs and wishes. The culture did not empower or support people to live fulfilled meaningful lives. Governance systems remained ineffective as they did not identify areas for improvement and when they did not enough action had been taken to improve the quality and safety of care.

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 05 October 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 16 and 22 August 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, person centred care, need for consent and governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective, and well-led which contain those requirements.

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.

For those 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 remained inadequate.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, and well led sections of this report.

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

Enforcement
We have identified breaches in relation to providing safe care, medicines management, infection control, safeguarding, consent to care, person-centred care and management of the service at this inspection.

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

The overall rating for this service is 'Inadequate' and the service remains 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.

Richmond Lodge

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 carried out by three inspectors.

Service and service type
Richmond Lodge 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. Richmond Lodge 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. A new manager had been in post for three months and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and clinical commissioning group who commissioned care 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
We visited the service on 7, 9 and 16 February 2023. We spoke with 10 staff members including the manager, senior team leader, team leaders, support workers and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 2 professionals who worked with the service. We spoke with 3 people who used the service. Not everyone living at the service wanted to speak with us, therefore we spent time observing interactions between staff and people. We reviewed a range of records. This included 4 people's care records and their medicine records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including incident management, improvement plans, and maintenance records were reviewed.

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider failed to ensure risks were assessed and managed. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of Regulation 12.

● Risks were not always assessed, managed, or monitored to keep people safe from harm. Risks associated with people's healthcare needs were poorly managed.
● A risk assessment relating to the management of diabetes was found to be inaccurate and unclear. For example, information relating to how much insulin should be given in an emergency was incorrect. This placed people at risk of harm.
● Staff failed to follow risk assessments in place. For example, we reviewed an incident where a person had become distressed. Staff failed to follow the risk assessment in place to support the person according to their needs which placed this person at risk of harm.
● Environmental risks were poorly managed. For example, monitoring of water temperatures were completed, however staff failed to take any action when water exceeded safe temperatures. This increased the risk of scalding. Some people living at the service were at risk of absconding and security at the service continued to be poorly managed. The gate and all doors were left unlocked throughout each of our inspection visits. Whilst there was a door alarm on the front door staff failed to respond to this. This meant risk reduction measures in place were ineffective which placed people at risk of harm.
● The provider did not ensure lessons were learnt when things went wrong. Known issues were not acted upon in timely manner. For example, an external auditor had completed a full audit of the home which had highlighted many of the issues we found during our inspection. However, little action had been taken which meant issues continued. This placed people at risk of harm.

Risk relating to the health safety and welfare of people were not effectively managed or monitored. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to manage risks associated with medicines. This was a breach

of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

● Medicines were not managed safely.
● People's medicine administration records were not completed in line with best practice guidance. For example, two people did not sign to witness written changes to medicine administration records. This increased the risk of medicine administration errors.
● There were missing records in place relating to medicines which were required 'as needed'. For example, one of these medicines included a rescue medicine used in the treatment of diabetes. This meant staff did not have instructions in how to safely give these types of medicines or when to give them. This placed people at risk of harm.
● Medicines were not always managed in line with best practice guidance. For example, there was no date recorded when insulin was opened. Manufacturers guidance states insulin should be discarded after 30 days of opening. Furthermore, we found insulin still in use which had expired two months prior to our inspection. Medicines should not be used after the expiry date as they may not be effective or safe to use. We fed this back to the manager who discarded this medicine during our inspection.
● There were no medicine records in place detailing how people liked to take their medicines or what support they required. This placed people at risk of not receiving their medicines safely or in their preferred way. We fed this back during our inspection and the provider took some action to address this issue.

The provider failed to ensure the safe management of medicines. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were at risk of infection due to poor infection prevention and control practices. The home was experiencing an outbreak of COVID-19 during our inspection which exacerbated those risks.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. Infection control guidance relating to the management of an outbreak was not always followed. For example, people continued to go out and visit places such as the pub whilst the service were experiencing an outbreak. There was no risk assessment in place to demonstrate why this decision had been made. This risked the spread of infectious diseases to the wider community.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home was visible dirty in places. For example, blinds were embedded with dust.

Systems had not been established to ensure infection prevention control measures were effective. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● The provider supported visits for people living in the home in line with current guidance.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse and neglect.
● Staff failed to recognise some incidents as abuse. For example, we observed an incident where staff spoke to a person unkindly which caused the person to become distressed, staff failed to recognise this practice as abuse. We reported this to the provider who commenced an investigation.

● Staff did not always take action to manage people's needs to protect people from the risk of abuse. For example, we reviewed an incident where a person was becoming distressed, staff failed to act which resulted in another person being hurt. Staff failed to recognise this as a safeguarding concern. This placed people at risk of avoidable harm.
● Staff completed training in safeguarding however this was not always effective as staff did not recognise or act on incidents of abuse. For example, staff told us, "We have training, but we don't really have any incidents here." Our findings throughout this inspection found this to be inaccurate. Failure to recognise incidents places people at risk of avoidable harm.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staffing and recruitment
● There were enough staff on duty however not all staff followed care plans, risk assessments and the providers own policies which meant people received inconsistent care and support. For example, we observed some staff to sit and engage with people to avoid periods of distress. However, we observed other staff to sit and ignore a person who was pacing around the lounge without any attempt to interact with them, this was not in line with the person's support plan. We fed this back to the manager who advised they would address this with staff to ensure people received safe and consistent care.
● Staff were recruited safely. This included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

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 inadequate. The rating for this key question has remained 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

At our last inspection the provider did not ensure people's needs were fully identified or met. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9.

● People continued to be at risk of receiving care which was not person-centred. As although some improvements had been made to support plans staff did not always follow support plans and risk assessments. We also found care plans relating to people's sexuality continued to be missing.
● People had 'Positive Behaviour Plans' in place however staff did not follow these to ensure people received person centred care. For example, a care plan detailed how to support a person and what type of language to use. However, we reviewed an incident where staff did not follow this, and the person became distressed.
● Although support plans included details and methods of communication needs. Some people had difficulty communicating with others. The provider continued to fail to ensure people had access to information in formats they could understand. For example, a care plan identified a person required picture aids to help make decisions. We observed staff to use verbal communication only to speak to the person. We asked staff who were supporting the person to find the picture aids referenced in the care plan, but these could not be found. These were eventually found by a senior member of staff however these pictures were very limited. This meant people did not have access to information to help them make day to day decisions.
● Staff did not always consider people's aspirations, goals and outcomes. For example, whilst one person was supported to express their views on activities they would like to complete, little action had been taken to support the person to undertake these. The person did the same activities with little variety. Furthermore, people were not always provided with choice in how they would like to spend their time. For example, a person who had been assessed as needing one-to-one support was provided with this support by accompanying staff to the tip, there was no evidence to support the person had chosen to do this. One-to-one support occurs when a care staff member is assigned solely to an individual person for a set period of time to meet their individual needs. Activities were poorly evaluated and did not demonstrate how people progressed with their hobbies, interests or in gaining independence.

The provider failed to ensure people's needs were met according to their assessed need. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider failed to ensure people's needs were fully met. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9.

● People's health needs were not always managed according to their individual needs. Whilst some improvements had been made to care plans relating to epilepsy, care plans relating to other health conditions such as diabetes were inaccurate and confusing. This increased the risk of people not having their personal health needs met.
● Staff did not always act in a timely manner in seeking care and support when people became unwell. For example, staff failed to seek medical attention or advice when a person living with diabetes presented with very high and low blood sugar readings. Staff did not act in line with the care plan in place. This was not person-centred and increased the risk of the person not having their health needs met.
● Advice from specialist healthcare teams was not always sought in a timely manner. For example, timely advice had not been sought for a person who lived with an unstable medical condition. This was not person-centred and increased the risk of the person not having their health needs met.
● Action was not always taken to support people who regularly refused meals. For example, one person regularly refused meals and staff documented breakfast was declined 6 days in a week. No action was taken to support the person to understand why nutrition was specifically important. This was not person-centred and did not follow the person's care plan.
● People's support plans did not always include outcomes from health appointments. This meant staff did not have clear guidance what instructions were given during these appointments. Whilst people had been supported to attend appointments such as the dentist since our last inspection there were not always follow up appointments planned or documented to ensure people received consistent care and support.

The provider failed to ensure people's needs were fully met. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Support plans demonstrated people were supported to visit their GP and other professionals such as opticians.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider did not have effective systems in place to ensure the service worked in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of

regulation 11.

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's rights under the MCA were not always respected.
● Where people required DoLS applications, these were completed and submitted to the local authority. However, we found where conditions were in place these were not always followed. This meant people did not always receive care and support in their best interest. Where conditions were not being met there was no risk assessment in place and the person received restrictive support unlawfully.
● The manager had completed capacity assessments which detailed people had been involved including what aids had been used. However, these were kept separately from people's care and support plans. We asked staff who were supporting people where these were kept, and they did not know. We asked the manager who located them in the office. Not having information readily available for staff to follow risked people's rights and liberty not being respected.
● People were not always supported in the least restrictive way. For example, we observed an incident where a person was told by staff to, "Come here you" whilst they were enjoying an activity and an item was then taken off them without any communication or consent being gained. Staff failed to recognise this as restrictive practice.
● Support plans had been completed by the manager however none of the support plans were signed by people or their representatives to say they agreed with the decisions made.

Effective systems were not in place to ensure the service worked in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. This was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Food was stored in an outhouse which only staff had the key too. One person's support plan detailed they did their own shopping and cooked their own food with staff support to increase their independence. However, the person could not obtain their own food without asking staff. This meant people did not always have free access to their own food.
● People told us they enjoyed the food. For example, a person told us, "We had stir fry tonight it was nice."
● People had a choice of food and menus on display included photos of food items to support people who had communication difficulties.

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

● The environment was not always homely and stimulating. Issues we found following our last inspection had not been resolved.

● Some areas of the home still required refurbishment, the provider told us this was in progress, and we observed samples of wallpaper on display so people could choose which they liked. People told us they had been asked which wallpaper they would like in the main lounge but were unsure if one had been picked.

● People's bedrooms were decorated with their own belongings. However, we found some bedrooms required decoration as some areas of the home were in a state of disrepair. The manager told us this was something they were actively working on.

Staff support: induction, training, skills and experience

● There was an induction and training programme. However, we found this was not always effective.

● Whilst staff received training in areas such as MCA and infection control, we observed training was not always effectively put into practice. The manager told us this was something they were already aware of, and this had been addressed through team meetings and supervision sessions.

● Staff told us they felt supported by the manager and received regular supervisions.

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 inadequate. At this inspection the rating 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; Continuous learning and improving care

At our last inspection the provider failed to have effective managerial oversight to ensure improvements were made. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

- Failings found at our previous inspection had seen limited improvements. Internal quality assurance processes were not effective in monitoring the service which resulted in poor care and an increased risk of avoidable harm.
- Medicine audits continued to be ineffective and had not identified any of the concerns we found during our inspection. We found a medicine audit for January 2023 had not been completed during our first day of inspection. However, during our second day of inspection records had been amended to reflect an audit had taken place in January 2023. We fed this back to the manager, and they confirmed an audit had not been completed and the records were inaccurate.
- Records relating to the level of support provided continued to be of a poor standard. For example, staff documented 'activity successful' repeatedly to evaluate different activities. This information did not detail what had worked well or whether the activities were meaningful.
- Audits continued to not be effective in driving service improvement. For example, health and safety audits had been completed and issues were either not identified or where they had been identified action had not been taken to address known issues.

The provider failed to learn, effectively monitor and improve the quality and safety of care. This was a continued breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider failed to have oversight of the service to ensure care was high quality. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

● The culture was not consistently person centred, inclusive or empowering.
● The provider failed to ensure the culture was person-centred, inclusive and empowering. Whilst people had been asked what activities they would like to take part in, people were not empowered to undertake them to improve their outcomes. We found people often accompanied staff in completing tasks rather than undertaking activities of their choosing. For example, we found a person's one-to-one support hours had been used to take another person to college. On another occasion we found a person's exercise had been documented as going to a supermarket.
● There was a poor culture within the staff team. Meaning care was not person centred and did not empower people to make everyday decisions. We observed people were not fully engaged or involved in day-to day decisions. For example, we observed staff to sit and fail to acknowledge a person walking up and down the lounge. Staff did not attempt to speak with the person about their day. Throughout our inspection visits staff continually left the back door open despite people saying they were cold on multiple occasions. Staff did not acknowledge this and continued to leave the door open. The provider failed to recognise the poor culture at the home which meant people were at risk of not being suitably supported.
● The provider failed to ensure legislation and best practice guidance in relation to supporting people with learning disabilities and autistic people was implemented at the home. Although support plans had been updated and people had been involved in creating these, the provider failed to ensure staff followed the support plans in place. This meant people did not always receive the right care and right support.
● Staff told us the manager was approachable and supportive however they felt other members of the leadership team did not always treat people with respect and ignored known issues. We fed this back to the manager and nominated individual who had commenced an investigation into concerns raised.
● A policy in place included protected characteristics but this was aimed at supporting the workforce and did not refer to people the service supported. Care and support plans did not consider all protected characteristics. For example, sexuality care plans were missing entirely for some people. This poor governance risked people's protected characteristics not being suitably supported.

The provider failed to have effective oversight to ensure people received inclusive person-centred care. This was a continued breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager was new to their post and had started to meet with all staff to discuss the service and how improvements could be made. People told us the manager had spoken with them to talk about the home and what they would like to change.

Working in partnership with others
● The service referred people to health and social care professionals. However as detailed within this report; these referrals were not always made in a timely manner.
● A professional we spoke with told us the provider did not always act on feedback which meant improvements were not made.
● Following our inspection visit the manager contacted a healthcare professional to organise specialist training to ensure people were supported effectively.

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 understood their responsibility in regards to duty of candour and informed people when things went wrong. For example, findings from our previous inspection had been shared with staff, people and their relatives.
- Records we reviewed demonstrated when things went wrong people were informed and apologies given.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people were supported in a person centred way, in line with best practice guidance.

The enforcement action we took:

We issued a notice to vary the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure care was delivered in line with principles of the Mental Capacity Act 2005.

The enforcement action we took:

We issued a notice to vary the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and manage risks, manage medicines safely and have effective infection control measures in place. This placed people at risk of avoidable harm

The enforcement action we took:

We issued a notice to vary the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were protected from abuse and neglect.

The enforcement action we took:

We issued a notice to vary the providers 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 have effective systems in place to monitor the quality and safety of care and support.

The enforcement action we took:

We issued a notice to vary the providers registration.