Broadoak Group of Care Homes

Lingdale Lodge

Inspection report

Lingdale
East Goscote
Leicestershire
LE7 3XW

Tel: 01162603738

Date of inspection visit:
05 February 2020

Date of publication:
15 April 2020

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Lingdale Lodge is a residential care home providing personal care to 44 people aged 65 and over at the time of the inspection. The service can accommodate up to 48 people in one adapted building.

People's experience of using this service and what we found
People were at risk of harm due to a failure to manage risks associated with hot surfaces, bedrails and the environment. Some people had sustained harm as a result of this. A failure to learn from incidents placed people at risk of harm. There was a risk people may not receive their medicines safely, when needed. Poor hygiene standards and a failure to follow infection control procedures meant people were at risk of infection.

People were, as far as possible, protected from the risk of abuse and improper treatment. Staff were recruited safely and there were enough staff to meet people's needs and ensure their safety.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

Care was not always provided in line with legislation and good practice. There was a risk people may receive inconsistent support with health conditions as staff knowledge was variable. Some people were at risk of malnutrition, records did not evidence they were provided with specialist diets recommended by health professionals. The home was adapted; however, some adaptations were not safe. Signage in some areas of the home did not create a homely environment. People were supported by staff who had access to a range of training and support.

People's right to privacy was not always respected. However, people were supported by kind and caring staff who knew them well and responded to their needs. People and their families were involved in decisions about their care.

People could not be assured that their concerns or complaints would be investigated and addressed as the provider did not follow their own policy. Overall, people received care that met their needs and reflected their preferences, their communication needs were met and they had been supported to think about and plan for their end of life wishes. People were provided with opportunities for activities and were supported to stay in touch with people who were important to them.

Systems to ensure the safety and quality of the home were not effective and practices were not based upon national good practice guidance and legislation. This had led to a failure to identify and safely address risks to people's health and safety. The registered manager had not identified serious incidents that placed people at risk. There had been a failure to notify CQC of some events within the service. In contrast, we

found the home had a positive atmosphere, people were happy with the service provided and staff felt valued. People, relatives and staff were involved in the running of the home and there were positive working relationships with partner organisations.

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 15 July 2017).

Why we inspected
Although this was a planned inspection based on the previous rating, the inspection was prompted in part by two specific incidents. One incident resulted in a person using the service sustaining a serious injury, the other incident placed a person at serious risk of harm. These incidents are subject to further investigations. As a result, this inspection did not examine the circumstances of the incidents.

The information CQC received about the incidents indicated concerns about the management of risks from hot surfaces and missing persons. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe 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.

Enforcement
We have identified breaches in relation to environmental safety, the safe use of equipment, decision making and governance 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Inadequate

Lingdale 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 Care Act 2014.

Inspection team
This inspection was carried out by three inspectors.

Service and service type
Lingdale Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, registered manager, assistant

manager, senior care workers, care workers and a member of the catering team.

We reviewed a range of records. This included seven people's care records and multiple medicines records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to support the evidence found. We looked at policies and procedures.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were at risk of burns from hot surfaces. There were exposed hot pipes throughout the home. The temperature exceeded safe levels specified by the Health and Safety Executive. One person had sustained a burn from a hot surface since our last inspection. Despite this, action was not taken to ensure people's safety.
- People were at risk of harm due to unsafe bedrails. Nearly all bedrails we reviewed were unsafe; some beds only had a bedrail on one side, bed bumpers did not cover the full length of some bed rails and there were gaps between bedrails and mattresses. All of these issues increased the risk of people sustaining an injury. One person had recently sustained an injury from unsafe bedrails. Action had not been taken to reduce risk which meant that people remained at risk of harm.
- People were at risk as the environment was not safe. An electric plant room with a high voltage warning sign was left open, as was an archive room which was stacked from floor to ceiling with records. Both areas presented a risk of injury to people.
- There was an increased risk of fire due to storage of superfluous items in electric plant rooms, this was located next to the archive area which was full of paperwork, this would increase the risk of fire spreading. In addition, emergency exit routes were obstructed by food trolleys and wheelchairs.

Preventing and controlling infection

- People were not protected from the risk of infection.
- The home was not clean and effective infection control procedures were not in place.
- Hygiene standards were poor. There was engrained dirt and dust in communal areas and bedrooms. Some toilet brushes were encrusted in bodily matter and debris had collected in hard to reach areas.
- Equipment was not clean. Beds, crash mats, bed bumpers and shower seats were dirty and some were in poor condition which posed a risk of infection harbouring.
- Staff did not follow good infection control procedures. We saw used continence pads and single-use gloves left on bedroom and toilet floors. In the laundry there was a large, odorous bin of soiled continence wear next to the washing machines posing a risk of contamination.

Learning lessons when things go wrong

- Opportunities to learn from incidents had been missed.
- There had been several incidents where people had sustained harm or been placed at serious risk of harm. For example, one person had been found on the side of a major road, the incident had not been investigated and measures put in place to reduce the risk of this happening again were not sufficient.
- Failure to learn from incidents placed people at risk of harm.

Using medicines safely

● There was a risk people may not receive their medicines safely, when needed.

● There were no staff on shift at night time who were trained in the safe administration of medicines. Several people were prescribed medicines to be given 'as required' to relive pain, anxiety and distress. These may have been needed at night, however, there were no measures in place to ensure people received these medicines in a timely manner. This placed people at risk of avoidable pain or distress.

● 'As required' medicines to treat anxiety were administered to some people regularly, but there was no evidence these medicines were given as a last resort. There was no information recorded about people's mental state leading up to administration or what other strategies, such as distraction or reassurance, had been tried before the use of medicines.

● Medicines were not stored safely; high risk medicines were not stored in line with legal regulations and we found a large jar of paracetamol labelled 'for staff use' stored in the medicines trolley. This was not safe and increased the risk of error. Furthermore, temperature control in the medicines room not effective which meant staff may not identify if the temperature exceeded the limit for safe medicines storage.

The failure to provide safe care and treatment and ensure the safety of the building and equipment was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were protected from abuse and improper treatment.

● People told us they felt safe and people's families agreed. One person told us, "I feel completely safe."

● The management team had identified potentially abusive practices and referred any allegations of abuse to the local authority safeguarding team when required.

● Staff knew how to recognise, and report abuse to the management team. They were also aware of external organisations they could report concerns to, such as the local authority.

Staffing and recruitment

● There were enough staff to ensure people's safety. This was reflected in people's feedback, one person told us, "There's plenty of staff."

● Staffing levels were based upon an assessment of people's dependency. Staffing rota's showed shifts were staffed at the level determined by the provider.

● Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

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

- People's rights under the MCA were not protected.
- Several people resided in shared bedrooms and were unable to consent to this. There were no assessments of people's capacity and consequently there was no evidence that this arrangement was in their best interest or the least restrictive option.
- The management team did not have a good understanding of how to apply the MCA to ensure people's rights were protected. On the second day of inspection the registered manager told us they had completed capacity assessments for room sharing. However, these did not accurately reflect people's needs, people's families and representatives had not been involved and there was still no evidence about why sharing a room was in people's best interests.
- Some people who required blended diets were routinely served cereal for their evening meal. Several of these people were unable to make a choice about what they ate and there was no evidence that this decision was made in their best interests.

The failure to act in accordance with the MCA and ensure care was provided in people's best interests was a 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
- Some people's health and wellbeing was at risk as records did not show they were provided with specialist diets.

● Weight records showed that several people had recently lost a significant amount of weight. A special diet and directions on how to record this had been provided by dietician for one person. However, monitoring of food and fluid intake was poor. Records did not evidence that the person was provided with the specialist diet. This posed a risk to people's health and wellbeing.

The failure to provide consistently safe care and treatment was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Overall, the meal time experience was positive. People were positive about the choice and quality of food and received timely assistance to eat when needed. One person told us, "The food is lovely we get enough. Sometimes they take us to the coffee shop in the village."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care was not always provided in line with legislation and good practice guidance.
The management team did not have a good knowledge of legal requirements, for instance in relation to managing risks from hot surfaces or bedrails. We have reported upon this further in the 'Safe' section of this report.
● People's needs were assessed prior to them moving into the home. This was used to develop care plans. However, care plans did not always provide an up to date account of people's needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● There was a risk people may receive inconsistent support in relation to their health.
● Care plans did not always contain enough information about people's health needs and we found staff knowledge in this area was variable. For example, several people had diabetes, however staff could not always describe the symptoms of high or low blood sugar. Some staff did not know they supported a person who experienced seizures. This posed a risk staff may not identify deteriorations in people's health.
● People told us they were supported with their health needs and people's relatives said they were kept informed about any changes to people's needs. One person said, "They are very capable managing my healthcare needs."
● There was evidence that advice had been sought from external health professionals, such as GP's and specialist nursing teams.

Adapting service, design, decoration to meet people's needs
● Although the home was adapted to meet people's needs, but the adaptations, such as bed rails, were not always safe. We have reported upon this further in the 'Safe' section of this report.
● Some signage throughout the home did not promote a homely environment, for example, there were notices for staff stuck on the walls in people's bedrooms and throughout communal areas.
● Although some people's bedrooms were homely and personalised, some people did not appear to have had a choice about the design and decoration of their bedrooms. For example, several men had the same floral bedcovers and walls that were painted in bright pink.

Staff support: induction, training, skills and experience
● People were supported by staff who had access to a range of training and support. This was reflected in people's feedback, one person told us, "The staff seem to know what they doing."
● Records showed staff had received the relevant training to equip them with the knowledge and skills they needed to support people who used the service. Staff had recently had "virtual reality" training in dementia, staff were all positive about this and said it helped them see through people's eyes.

● New staff received an induction when they started work at the service. Staff were positive about this.
● Staff told us they felt supported and records showed they had regular formal and informal opportunities to discuss and review their work, training and development needs.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people were not always treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People's right to privacy was not always respected.
- Several people shared bedrooms. Some of the people who were sharing bedrooms were assisted with continence care in bed, they were only separated from the other person by a privacy curtain. This did not promote people's dignity or respect their right to privacy. Shared rooms also meant that some people had very limited opportunities to spend time alone.
- Clocks throughout the home were not set correctly, several showed the wrong time and date. This did not support people's independence and could have led to confusion for people living with dementia or memory loss.
- Some care plans contained contradictory information about how to maximise people's independence. For example, one person's care plan stated they could make decisions in a certain area, but later in the care plan it said they did not have capacity to make decisions in the same area. Despite this most staff had a good understanding of how to support people's independence. A member of staff told us, "We encourage them to wash themselves. If struggling to feed themselves we put it on the spoon and put the spoon in their hands. Although we are doing some of it, were getting them do some of it as well."

Ensuring people are well treated and supported; respecting equality and diversity
- People were supported by kind and caring staff.
- We received positive feedback from people and their families about the staff who supported them. One person told us, "The staff are very kind to me," another commented, "Staff are lovely and wonderful."
- Staff had a positive outlook and this had led to a homely atmosphere at the home. A member of staff told us, "I love working there. The atmosphere, we all get on with each other. Were like one big family, we look after each other. Were all there for the residents and that the main thing." Another member of staff said, "It's such a loving and caring environment everyone is really friendly."
- Staff were responsive to people's anxiety and distress. Staff described how they calmed people when they were upset. This was supported by our observations.
- The caring approach extended to people's families. A member of staff told us, "We ask families if they want to stay for lunch or tea. Try and get them involved as much as possible. We want the family to get to know us as well. We have coffee mornings and clothes shows and invite families in."
- People's diverse needs were considered and accommodated. Staff told us about one person whose religious beliefs meant they did not wish to take part in some activities, staff respected this.

Supporting people to express their views and be involved in making decisions about their care
- People told us they were involved in decisions about their care. One person commented, "I have a choice

for clothes and food. They ask my opinion."

● Staff described involving people in their care as much as possible. A member of staff told us, "I'll say what would you like to wear, I'll get the flannel or whatever they like to use, I show them where to wash and prompt them."

● People and their families were involved in developing their care plans. The registered manager explained that they spent time with people and their families to learn about what mattered to them and their support needs. There was personalised information about people's likes, dislikes and personal histories in care plans.

● People were supported to access advocacy to help them express their views. There was information about local advocacy services displayed in the home and the management team understood when a referral to advocacy would be required.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant there was a risk people's needs were not always met.

Improving care quality in response to complaints or concerns

- People could not be assured that their concerns or complaints would be investigated and addressed.
- There were no complaints recorded. However, before our inspection we were made aware of a complaint about the conduct of staff. This was not recorded in the complaints log and there was no formal investigation of the concerns raised. This was not in line with the providers complaints policy and posed a risk that issues raised by people and their families may not be addressed.

- Despite the above, people and their families told us they would feel comfortable raising concerns with the management team and stated they had confidence that concerns would be acted upon.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People told us they received care that met their needs and reflected their preferences.
- The quality of care plans was variable. Although we found most staff had a good understanding people's needs, it meant people were at risk of inconsistent support.
- People had been supported to think about and plan for their end of life wishes. This was recorded sensitively in people's care records. Relatives had provided positive feedback on the caring and compassionate support their families received in their last days of life.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were met.
- There were signs and posters throughout the home to aid people's communication. In the dining room there were pictures of the food and communication books with symbols were available to staff so they could support people's communication.
- The registered manager told us they used photos and images to aid people's involvement in care plans.
- Most care plans contained detailed information about how people communicated and we observed staff had a good understanding of this.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were provided with opportunities for activity and were supported to stay in touch with people who were important to them.

● There was a programme of activities, the activities coordinator met with people and their families regularly to learn about people's interests. Activities included games, exercise sessions, art and craft and music. Staff spent structured and informal time with people and when the activity coordinator was not present.

● People were supported to go out and about. Staff accompanied people into the local community, for example one person frequently tried to leave the home, staff responded by taking them for a local walk, this reduced their anxiety. Other people were supported to go out shopping and on day trips.

● People's families and friends were welcomed into the home. Visitors to the home were positive about the atmosphere and told us staff were friendly and welcoming.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; Continuous learning and improving care

- Systems to ensure the safety and quality of the home were not effective and practices were not based upon national good practice guidance and legislation. This had led to a failure to identify and safely address risks to people's health and safety as detailed in the "Safe" section of this report.
- Quality assurance audits were not comprehensive, for example, health and safety checks completed by the registered manager had not identified the concerns we found with hot surfaces and bedrails.
- The provider and registered manager had not kept up to date with national legislation and guidance. The provider and registered manager were not aware of the Health and Safety Executive Guidance on the safe use of bedrails or on managing the risks from hot surfaces. This had exposed people to the risk of harm.
- The response to some of the concerns raised throughout inspection were not well thought through and consequently did not mitigated risk. For example, when we raised a concern about the lack of medicines trained staff on shift at night the registered manager immediately developed a risk assessment which did not address the issues or mitigate the risk.
- The registered manager had not identified serious incidents that placed people at risk of harm. Consequently, improvements had not been made to ensure people's health and safety.
- The issues with governance and leadership meant we were concerned that people were at risk of harm.

The failure to ensure effective governance and leadership was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There had been a failure to notify CQC of some events within the service, which the provider is required to by law. We had not been notified any DoLS notifications since March 2017. A failure to notify us as required can have a negative impact on our ability to monitor the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations.

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

- Although the registered manager had informed people and their families when something had gone wrong, the failure to investigate and learn from adverse incidents meant they were not able to offer any assurances about improvements to care following incidents.

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

● Despite our findings about the safety of the service we found the atmosphere of the home was positive. The registered manager and staff team spoke passionately about providing people with good care and making a difference to people's lives. The registered manager told us, "We put our heart and soul into this place."

● Staff were positive about the registered manager. They told us she was approachable, supportive and led by example. One member of staff told us, "The manager is on the floor, she's not one that sits in the office. She's not afraid to role her sleeves up."

● Most staff felt valued in their roles. A member of staff told us, "If we've done something really well, they'll say that's really good." We found this resulted in staff feeling passionate about their roles and motivated to provide good care to people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People, relatives and staff were involved in the running of the home and there were positive working relationships with partner organisations.

● People living at the home were invited to regular meetings to discuss and share feedback on activities, events and the food. People and their families could also provide feedback in customer satisfaction surveys. The results of the most recent survey were positive.

● Regular staff meetings were held to share information with staff and address performance issues.

● There were links with local health and social care professionals. A GP visited the home regularly to attend to people's non-urgent health needs. During the inspection the provider made contact with the local authority to request support to make the required improvements, from the areas we had identified.

● The home was part of a pilot programme exploring how best to support people with dementia.

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 11 HSCA RA Regulations 2014 Need for consent People's rights under the MCA were not respected. Regulation 11 (1)

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 People were not provided with safe care and treatment. Risks associated with bed rails, hot surfaces and the environment placed people at risk of harm. Medicines were not managed safely and infection control practices were poor. Regulation 12(1)

The enforcement action we took:

We took urgent action to impose conditions on the registration of the provider which required them to act to ensure people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the safety and quality of the service were not effective, this had resulted in a failure to identify issues which consequently placed people at risk of harm. Regulation 17(1)

The enforcement action we took:

We took urgent action to impose conditions on the registration of the provider which required them to act to ensure people's safety.