Maria Mallaband Properties (4) Limited

Cavendish Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Cavendish Court is a residential care home providing personal and nursing care to 35 people aged 65 and over at the time of the inspection. Some of the people accommodated were living with dementia. The service can support up to 43 people. The accommodation is provided over three floors, each of which has separate adapted facilities.

People's experience of using this service and what we found
The service was not well-managed at the time of this inspection. We found improvements were needed to ensure people always received safe, effective, and responsive care that met their needs.

Risks to people's health and welfare were not always identified or managed effectively. We found that one person was at risk because staff were unaware of safeguards that had been put in place to safeguard them from the risk of falls. Another person had remained at risk and had suffered falls because advice provided by their doctor had not been acted upon.

Information to be supplied to the fire service in the event of a fire contained inaccuracies. The housekeeping trolley, which held hazardous substances, was left unattended in the presence of vulnerable people.

Systems to safeguard vulnerable people from abuse where not always followed and two care staff spoken with were unclear on the provider's safeguarding procedures.

Staff were employed in sufficient numbers but oversight in their management resulted in 12 vulnerable people being left unsupervised for a period.

Staff needed further training on the Mental Capacity Act to ensure people received the right type of support to assist them in their decision-making and the provider was not meeting the conditions upon which a person's Deprivation of Liberty had been granted.

People and their representatives were not sufficiently involved in the care planning process and care plans were not always person-centred so did not confirm the relevant person's needs or personal preferences.

The provider's quality assurances systems had either not identified the improvements needed at this care home or sufficient action had not been taken in a prompt manner to address the improvements which were needed.

Although there were areas for improvement, all the people who lived at the home had something positive to say about the staff and the standard of care provided.

Nursing and care staff were seen to be kind and caring in their approach. They engaged with people

sensitively before providing support and care and they listened and acted on what was said to them.

Medicines were managed safely, and a visiting doctor told us that managers and staff worked collaboratively with them to ensure people's health care needs were met.

People's nutritional needs were being met and comments about the standard of food were generally positive.

The registered manager worked diligently throughout the course of our inspection and instigated improvements. These included a series of person-centred reviews and monthly residents and relatives' meetings going forward. This will help to ensure that people are supported to express their views and be involved in decisions about their 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 good (published 29 July 2021). At this inspection we found the provider was in breach of regulations. The service is now rated requires improvement.

Why we inspected
We received concerns in relation to the safe and effective care and management. As a result, we commenced a focused inspection to review the key questions of safe, effective, and well-led only. It became clear during the inspection that improvements were also required in the remaining key questions caring and responsive. We therefore broadened the inspection to include all key questions and in doing so completed a comprehensive inspection of the service.

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.

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

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, consent, person centred care and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

We have made recommendations about safe staffing levels and accessible information.

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 request an action plan from the provider to

understand what they will do to improve the standards of quality and safety. 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Cavendish Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team included 2 inspectors, a Specialist Advisor, a nurse and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cavendish Court is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Cavendish Court is a care home with 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 a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service 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
We spoke with 17 people who used the service and 8 family members about their experience of the care provided. We spoke with 21 members of staff including the registered manager, regional director, 4 members of the provider's quality team, 2 nurses, 7 care staff, a health care practitioner, an administrative assistant, an activities coordinator, the head housekeeper, a housekeeper and chef.

We reviewed a range of records. This included 11 people's care records and multiple medication 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 policies, procedures and audits, were reviewed. We spoke with a visiting health and social care professional and corresponded with the visiting doctor to gather their views about partnership working and the quality of care provided.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management Learning lessons when things go wrong.
● Risks to people's health and welfare were not always identified or managed effectively.
●We carried out this inspection the light of four recently substantiated safeguarding investigations which identified unsafe care, inadequate recording, poor communication and ineffective care planning, monitoring, and review.
●The provider's quality team was in the home supporting the manager to address the required improvements identified in the light of the four recently substantiated safeguarding investigations and internal audits. However, further improvements were required to ensure people were safe.

● A person's care plan and other important documents such as the shift handover sheet did not accurately reflect the measures in place to reduce their risk of falls. This person was known to be at high risk of falls and had been provided with a pressure sensor alarm to be placed on their chair. This was designed to alert staff when the person attempted to move. We found this person sat unsupervised on two occasions when staff had failed to put the pressure sensor alarm in place. This put the vulnerable person at increased risk of falls.
● We observed the housekeeper's trolley which contained hazardous substances was left unattended on the 2nd floor. This put vulnerable people at risk of harm.
● Personal Emergency Evacuation Plans (PEEPs) were in place and easily accessible, in a grab bag kept in the foyer. The PEEPs register which would be handed to fire officers in the event of a fire contained inaccuracies. This could cause unnecessary confusion and/or delay in the event of a fire.

The provider had failed to ensure effective systems were in place to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. 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.

Action was taken to address the issues we identified throughout the course of our inspection. It is imperative that these improvements are maintained and sustained.

● Health and safety checks in relation to the environment and equipment were regularly carried out.

Systems and processes to safeguard people from the risk of abuse
●The provider's 'Adult Safeguarding' policies and procedures were not always put into practice.
● Records showed that a vulnerable person had been physically assaulted by another vulnerable person and suffered injury. This had not been reported to the local adult safeguarding authority in accordance with locally agreed adult safeguarding procedures. The Care Quality Commission had not been notified of this

occurrence in accordance with the registered person's responsibilities and conditions of registration.
●Staff had received training on adult safeguarding procedures, but some were unclear on which agency to report evidence or suspicion of abuse to. They were also unclear of the protections afforded to 'whistleblowers' under the provider's whistleblowing policy and the Public Interest Disclosure Act 1998.

The provider had failed to ensure systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were enough suitably, skilled, and experienced staff on duty to meet people's needs. However, staff were not always deployed effectively to provide safe support .
● On the first day of our inspection we found that only one member of staff was on duty alone on the second floor attending to the needs of 13 vulnerable people. When this staff member assisted one of the people to use the toilet it meant 12 vulnerable people were left unsupervised. This put them at risk of accident and injury. The registered manager explained three staff were rostered to work on this floor but unbeknown to him two had been taken off the floor to engage in fire training. Action was taken to prevent a recurrence.
●Some visiting relatives raised concerns about staffing levels. One relative said their family member had to wait almost an hour to receive personal care on one occasion.
● Nurse calls bells were monitored for response times which appeared adequate in the main with a few exceptions including 9, 17, and 23 minute delays. There was no indication the reason for these delays had been explored.
● The number of staff on duty and skill mix was determined based on people's needs and dependency levels. However, the analysis we saw was for the whole home and it was not clear how the layout was taken into consideration.

We recommend a staffing needs analysis is carried out for each separate floor illustrating how safe staffing levels will be maintained when staff take breaks or attend training.

● The provider followed safe procedures for the recruitment of staff and all appropriate checks had been completed before new staff were employed in the home. There were some minor shortfalls which were addressed at the time of inspection.
●People spoke highly of the staff often commending them for providing good standards of care.

Using medicines safely
● Medicines were received, stored, administered, recorded, and disposed of safely.
● There were some gaps to the records of topical medicines, including barrier creams at the beginning of the inspection. These improved during the inspection.
● Staff involved in administering medicines had received training and had access to relevant guidance regarding the administration of medicines which may be needed on an 'as and when required' basis.
● Medicines audits were carried out regularly.

Preventing and controlling infection
● Effective systems, policies, procedures, and practices were in place to ensure people were protected from infection including COVID-19.
●The provider was enabling visiting in line with government guidelines.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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 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.

- The provider was not always working within the principles of the MCA.
- A person's Best Interests Assessor (BIA) appointed by the supervising authority (local authority) found four out of five conditions on their DoLS authorisation were not being met by the provider. The BIA reported the matter to the local adult safeguarding authority.
- The registered manager had not informed the supervising authority the home was struggling to meet the conditions. In such cases, the care home needed to report back to the supervising authority otherwise the DoLs would not be valid, and the deprivation of liberty considered illegal.
- For another person there were contradictory statements in their documentation, as to whether they had capacity to give consent. A mental capacity assessment (MCA) concluded they did not have capacity but suggested they were able to give verbal consent. By necessity the MCA is designed to determine whether the person has capacity to give consent or not. Another MCA concluded the person did not have capacity but a relative had given consent on their behalf. A person is not able to give consent on behalf of another person and any such decisions where a person is assessed as not having capacity must be determined via a best interests' process and recorded.

We found no evidence that people had been harmed. However, the provider's systems were either not in place or robust enough to ensure consent to care and treatment was sought in line with law and guidance. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always appropriately assessed. Falls risk assessments and care plans were not always reviewed or where necessary revised when a person suffered a fall.
●Records showed that a doctor told staff that a person who had seven falls in a short period of time needed to be assessed for 1-to-1 care in the interest of keeping them safe. This was not acted upon, and no such assessment was requested or carried out. Over the following six-week period the person suffered a further three falls.

The provider failed to establish effective systems to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Two staff lacked basic knowledge safeguarding processes and refresher training was required on record keeping, and MCA.
● New starters received induction training over a 12-week process although one new recruit's induction booklet was signed off as complete just 4 days after they started work. The weekly orientation section of the booklet had only the first week completed. We found that this person lacked basic knowledge of some people's needs.
● The provider's quality team were in the home throughout the course of the inspection supporting the registered manager to address required improvements which included staff training.
● Staff told us they were trained to meet people's needs and records showed that they had received training and updates on a range of appropriate topics.
● Staff told us that they were well supported, and records showed they benefited from regular supervision meetings with their manager.

Supporting people to eat and drink enough to maintain a balanced diet
● The nutritional needs of people were being met. Staff were aware of people's dietary needs and preferences.
● We observed positive interactions and support being provided to people at mealtimes.
● People's comments about the food were generally positive. These included, "The food is very good. The staff give me a choice of two things before lunch. Today I requested mash instead of chips which was nice" and "Staff are brilliant. Help if needed, food good, good general ambience." A relative said their family member was offered choice and enjoyed the food.
● There were no written menus at the start of the inspection and the notice board had the previous days menu displayed. This was rectified during the inspection; printed menus were made available and illustrated booklets were available to help people make an informed choice.

Adapting service, design, decoration to meet people's needs
● The accommodation was suitably adapted to meet people's needs.
● People's rooms were personalised with photographs and other treasured items.
● Careful thought had been given to the colour of crockery and tablecloths to assist people with dementia and the registered manager had some innovative ideas to help people identify with their personal rooms.

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

Supporting people to express their views and be involved in making decisions about their care; ensuring people are well treated and supported; respecting equality and diversity

- People did not always receive the right level of support and care because they and their representatives had not been sufficiently involved in planning and reviewing their care. Care plans did not always record their needs and personal preferences in sufficient detail and some staff lacked knowledge around people's preferences and needs.
- One person told us that they had been bathed by male staff which they would not choose and a relative of another person told us that their relative would not wish to be bathed by male staff. Their respective care plans did not record their personal preferences in sufficient detail.
- Relatives told us how disappointed they were to find their family member wearing clothes that did not belong to them and would not choose to wear. There were clothes in their wardrobe that did not belong to them.

The provider had failed to ensure people were always involved in their care planning and care plans lacked important information. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider's 'Feedback policy' was not always put into practice. Residents/relatives' meetings for March and April had not taken place. Following a meeting in May a relative told us that they were not being listened too or taken seriously because issues they had raised had not been documented in meetings minutes or responded to.
- A visiting relative told us, "I am aware of residents' and carers' meetings. If these were programmed, it would be better. In the past they have been cancelled or rearranged last minute."
- The registered manager implemented a series of person-centred reviews during our inspection and programmed monthly residents and relatives' meetings going forward. This will help to ensure that people are supported to express their views and be involved in decisions about their care.

Respecting and promoting people's privacy, dignity, and independence

- Nursing and care staff were seen to be kind and caring in their approach. They engaged with people sensitively before providing support and care and they listened and acted on what was said to them.
- All the people spoken with had something positive to say about the staff and the care they received. Their comments included, "Staff are excellent nothing is too much trouble", "The staff are lovely, and they give me help to dress if needed. I resented coming in here, but staff helped me to settle in. Staff are not rushed." and

"Its wonderful here, the staff, the food, the care excellent."

- We observed staff knocking on people's door prior to entering their room.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider did not ensure care plans accurately reflected people's needs. People and their representatives were not sufficiently involved in planning their care.
- One person's care plans were not sufficiently person centred because important information such as the pain they experienced, barrier creams prescribed by their doctor and changes to their medication had been omitted from their care plans.
- Another person care plans lacked important details. Their care plans made no mention of a particular medicine prescribed by their doctor to treat a certain condition on an 'as and when required' basis, when it should be used or alternative interventions that should be tried first. Their skin integrity care plan made no mention of a moisture lesion, or topical cream prescribed by their doctor for a specific area.
- A visiting relative spoke of their concern that their relative's needs were not being met. We looked at the person's care plans and could see that they did not accurately reflect their needs. Their personal care records showed that their needs had not always been met. This put them at increased risk of harm.

The provider had failed to ensure people were always involved in their care planning and care plans lacked important information. This was a further breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection the registered manager implemented a series of person-centred reviews with the aim of developing arrangements for care and care plans that reflected each person's needs and personal preferences.
- People told us how nursing and care staff supported them to make choices in their daily living. One person said, "I can choose when I go to bed and shower when needed."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider had arrangements in place to support people with their communication needs. However, these were not always put into practice. On the first day of the inspection there were no written menus and no arrangements to assist people who could not read to make an informed choice.

● The registered manager introduced booklets of pictograms to aid communication but staff were not routinely using these.
● English was not the first language of one of the people who lived at the home and because they were living with dementia their command of it was failing, leading to risk of isolation. Care plans had been adapted with pictograms and part written in their first language to aid communication. The registered manager was endeavouring to engage the services of a person who would be able to speak this person in their first language, but so far had not been successful.
● The statement of purpose, service users guide, complaints procedure and other important documents could be made available in different languages and formats. However, there was no mention of this in the various documents.

We recommend that the provider adds an addendum to the statement of purpose, service users guide, complaints procedure and other important documents that each document can be provided in other languages and formats upon request.

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
● The service employed a part time activities coordinator and was in the process of recruiting another. In the interim other arrangements were being made to provide people with opportunities to engage in activities and pass times.
● We observed people engaging in activities on each day of our inspection some led by care staff and others led by the part time activities coordinator.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place. Information on how to make a complaint was clearly visible to people and visitors.
● The registered manager maintained a record of complaints including details of investigation and action taken to improve the service where appropriate.

End of life care and support
● People had care plans in place that recorded and respected their needs and wishes regarding care at the end of their life. This included spiritual needs and preferences expressed by the person or their next of kin.

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 requires improvement. 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; continuous learning and improving care

- We carried out this inspection the light of four recently substantiated safeguarding investigations which identified unsafe care, inadequate recording, poor communication and ineffective care planning, monitoring, and review. During the course of our inspection we identified failings in recording, assessment, care planning, MCA and DoLs which put people at risk of harm.
- Although the provider's quality team was in the home supporting the registered manager to address identified failings, progress was inadequate to ensure the people who lived at the home received safe, effective, and responsive care.

- On the first day of the inspection we found that staff were not maintaining accurate, complete, and contemporaneous records (made at the point care is given) in respect of each person who lived at the home. This put people at risk of their needs not being met.
- We were given assurances that going forward systems had been put in place to ensure accurate, contemporaneous records would be maintained. However, later we observed two care staff writing the personal care records for 13 people from memory several hours after the event. A senior care worker told us that this was common practice on this floor of the home. Such records cannot be relied upon or considered to be an accurate record of care provided.
- Our comprehensive inspection June 2019 identified breaches of regulations 12 and 17. The provider took action to make the necessary improvements and was found no longer in breach of regulations at our comprehensive inspection June 2021. Improvements following our inspection in 2019 had not been sustained.

The provider's systems were either not in place or robust enough to assess, monitor and improve the quality and safety of the service or mitigate the risks relating to the health, safety, and welfare of people. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager demonstrated an understanding of their responsibilities under duty of candour.
- We saw that the relevant people had received an explanation and apology for incidences that had occurred in October 2022. There was no evidence that the relevant people had received an explanation or

apology for incidences that had occurred this year. The registered manager rectified this before the end of the inspection.

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

● People had not always had the opportunity to share their views and be fully involved in the planning of their care and the running of the service. Resident and relative meetings were inconsistent, and relatives of vulnerable people told us that they had not been sufficiently involved planning their family member's care.

● The registered manager addressed this during the inspection by instigating a monthly programme of resident/relative meetings and person centred reviews.

● Nursing and care staff had received training on Equality and Diversity and were aware of protected characteristics under the equality Act 2010.

Working in partnership with others

● A visiting doctor told us that managers and staff worked collaboratively with them to ensure people's health care needs were met.

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 9 HSCA RA Regulations 2014 Person-centred care People were not always involved in their care planning, care plans lacked personal details.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were either not in place or robust enough to ensure consent to care and treatment was sought in line with law and guidance. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service.

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 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to assess, monitor and improve the quality and safety of the service or mitigate the risks relating to the health, safety and welfare of people. This placed people at risk of harm.

The enforcement action we took:

served a waring notice