Burlington Care Homes Limited

Clipstone Hall & Lodge

Inspection report

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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
Clipstone Hall and Lodge is a residential care home providing accommodation and personal care to up to 90 people. The three storey premises were purpose built and were surrounded by gardens. The service provides support to people over 65 years of age, some of whom were living with dementia. At the time of our inspection there were 60 people living the service.

People's experience of using this service and what we found
People were at risk of infection due to poor infection control practices. Premises and equipment were not clean or hygienic and staff were not clear on their responsibilities.

People did not receive their medicines safely. People were at risk of receiving their medicines in appropriately and against manufacturers guidance.
Whilst people told us they felt safe, there had been limited action to assess, monitor or improve the safety of the service and where action had been taken it was not clear or co-ordinated.

Identifying and reporting of risks, issues and concerns were unreliable and inconsistent. Where issues had been highlighted action was slow to be taken.
Roles, responsibilities and accountability arrangements were not clear and identified known issues were repeated.

People did not always receive personalised care and people's care plans did not always contain relevant up to date information.

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

Safeguarding systems and processes were in place and people were protected from the risk of abuse, harm and neglect.

Staff were recruited safely. People and relatives told us they were happy with the care provided and felt well supported by caring staff.

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 the service under the previous provider was good, published on 1 August 2019.

Why we inspected

This service was registered with us on 6 February 2020 and this is the first inspection.

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.

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

We have identified breaches in relation to person-centred care planning, safe care and treatment of people, governance and leadership and staffing at this inspection.

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

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? 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 well-led. Details are in our well-Led findings below.	**Inadequate**

Clipstone Hall & 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
The inspection was carried out by two inspectors, a specialist advisor 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
Clipstone Hall and 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. Clipstone Hall and 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not 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 it had come under new ownership. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with seven people and six relatives of people who used the service about their experience of the care provided. We spoke with nine members of staff including the manager, quality manager, care assistants, domestic staff, kitchen staff and activity co-ordinator. We also spoke with four professionals who worked with the provider.

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

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely; Learning lessons when things go wrong

- People did not receive their medicines in a safe or timely manner.
- Medicines administration practice was not consistently hygienic. We observed a staff member administering medicine. The medicine was dropped onto the floor, wiped with kitchen towel and administered to the person. This is not in line medicines administration best practice.
- Staff did not have access to all the information and paperwork they needed in order to support people with their medicines safely. For example, there was not enough information available to staff to know when to administer time specific medicines. This meant manufacturers guidance was not always followed and placed people at increased risk of harm.
- Topical medicines, for example body creams, were not always recorded appropriately. Records did not detail the area of the body the medicine was applied to. This increased the risk of people receiving their medicines inappropriately and against guidance.
- People newly admitted to the service had not had their medicines assessed reviewed or recorded. This placed people at risk of not receiving their medicines or not receiving them as they preferred.
- Lesson were not learnt when errors or incidents had been identified and recorded. This resulted in errors being consistently repeated. People were at ongoing risk of being over or under prescribed their medicines.
- Audit processes were not robust and not always completed. We observed examples of audits being completed by staff who had completed the tasks. This meant the provider was not ensuring steps reasonably practicable to mitigate risks to people.

Preventing and controlling infection

- The service did not follow or meet national guidance in relation to infection control which placed people at risk of infection.
- Staff were not clear on their responsibilities which had resulted in communal areas including kitchenettes and dining rooms not being cleaned regularly. Staff told us they did not have enough time to incorporate cleaning duties alongside care tasks. Clarification was sought from the manager; however, they were not aware of the issue.
- Staff wore appropriate personal protective equipment (PPE), however PPE was not always removed and disposed of safely following contact with people. This increased the risk of infection spreading.
- Good food hygiene practice was not being followed in communal kitchenettes. We observed uncovered and out of date food stored in cupboards. This placed people's health at risk.
- Equipment and aids were also found to be dirty and non-operational. For example, in a bathroom we found an electric hoist bath chair had been out of service since 2016. People living at the home had access

to this equipment which placed them risk of harm if they attempted to use the bath.

The provider failed to ensure that medicines were administered safely and failed to ensure correct procedures to prevent and control the risk of infection were implemented and followed. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- Visits to the home were happening in accordance with current guidelines. Friends and relatives were required to use a booking system to arrange visits to ensure the provider could monitor numbers of people within the home to mitigate risk of infection.

Staffing and recruitment

- Staff deployment meant people's needs were not met in a timely manner.
- Staff felt there were not enough care staff on shift and that seniors had other duties and were unable to always assist with supporting people. Staff explained, "It can be quite hectic, and we have people who need double up support, so when seniors have meetings there is no one to replace them."
- Staffing levels were in line with the providers dependency tool. However, staff were deployed on capacity rather than care needs. People who required support with complex care tasks were supported by fewer staff. This resulted in people waiting extended periods of time for support.
- A relative told us, "They have moved [relative] downstairs, I'm happy as there never seems to be enough staff upstairs."
- We observed people being supported with tasks by domestic staff and the activities co-ordinator such as moving around the home and supervision at mealtimes. This prevented staff from completing tasks they were responsible for.
- Staff had not been trained in line with the providers policy or for specific health tasks. For example, the providers medication policy stated that all staff received medicines training, however records showed only 8 staff members had received this training.
- We observed staff on their personal mobiles in communal areas whilst supporting people. This was brought to the managers attention during the inspection and they acted immediately.

The provider failed to ensure staff were deployed in such a way to meet people's needs and failed to ensure staff had the appropriate training. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff were recruited safely. Pre-employment checks, such as seeking references and DBS checks, were carried out.

Assessing risk, safety monitoring and management

- Risks to people were not always managed safely.
- We reviewed care plans which did not contain risk assessments for peoples identified needs. For example, a person living with diabetes had no nutritional plan in place to support with their condition. This meant they were at risk of receiving food that was nutritionally inappropriate.

● Where risk assessments were in place, they were not always robust or personalised. For example, there were no clear instructions for staff on how to support people with their personal care and how often, therefore people were at risk of not having needs met effectively.
● Moving and handling equipment people had been assessed as needing to support them with their care and mobility, were found stored within people's personal bathrooms. This meant people had restricted access to these areas which did not reflect people choices of how they wished to receive their care nor promote their independence.

● The manager advised they completed daily walk rounds of the home but was not aware of the issues around cleanliness and storage of equipment and advised this would be reviewed as a priority.
● Long serving staff knew people well and this experience gave them a good insight into what risks people faced. People and relatives told us they felt safe within the home. One person said, "They know me and my needs. I feel safe and I'm included in everything; I couldn't be happier."

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of harm and abuse.
● Staff were knowledgeable about the risks of abuse and knew how to report this appropriately.
● There was a clear policy in place that supported staff in raising their concerns. One staff member told us, "My concerns are always listened to, no matter how small they seem". This ensured people's risk of neglect and abuse were identified and acted upon.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
- People's needs were not always fully assessed.
- Pre-admission assessments were not completed and recorded in a timely manner. We observed assessments that had not been recorded 48 hours after admission. This meant staff did not know how to fully support people inline with their needs or wishes.
- Care plans did not contain sufficient information relating to people's health needs. For example, one person's care plan stated they had a choking risk but there was no nutritional plan to enable staff to support them. This placed the person at risk of receiving unsafe care in relation to their healthcare needs.
- Some care plans contained limited information and although reviews had taken place monthly information to reflect changes had not been updated in over a year. Staff did not have consistent information about people or their current needs in order to provide optimal care and support to everyone living in the service.
- The manager was aware of the issues identified and acknowledged the gaps within people's care plans. They advised full reviews of people's needs were being undertaken which would ensure safer care delivery.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- People were not always supported to access other services in a timely manner.
- One visiting professional who works with the service told us "Staff don't always alert us to their concerns, and this delays me from supporting people properly, I find I have to chase staff up for information I have asked for".
- We saw evidence of appointments for people with medical professionals but there was no follow up action recorded. This meant people's care was not effective and people were at risk of receiving care not in line with changing medical guidance and recommendations.

Staff support: induction, training, skills and experience
- People were supported by experienced staff, however training records showed gaps in peoples ongoing learning and development.
- For example, some people living at the home were at risk of falls. Records showed staff had not received falls prevention and awareness training. This placed people at a higher risk of falls or from preventable falls reoccurring.
- Staff received induction training and attained The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and

social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme and were supported by regular supervisions.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet.
● We observed people being offered choice and encouraged to make decisions about what they wanted to eat and drink.
● People said that although there was sometimes a short wait for a staff member to be available, they were extremely happy with the meals provided. One person said, "The food is beautiful, you get plenty of choice and if I don't like it they will make me something else".

Adapting service, design, decoration to meet people's needs
● People were involved in decisions about the premises and environment.
● People were able to choose the decoration within their own bedrooms and were supported by staff who promoted choice. People told us they felt at home.
● Dementia friendly signage was present throughout the home which supported people living with the condition to be as independent as possible.

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.

● Consent to care was sought in line with legislation and guidance.
● Where restrictions were identified, DoLS applications had been made to ensure these restrictions were lawful.
● Relatives told us they were involved in the decision-making process of the DoLS applications and staff were knowledgeable and capable when supporting them.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect.
- We noted some people's rooms were untidy and there was food debris on furniture and floors that appeared to have been present for a substantial period.
- We observed one person receiving their medicine during the lunch service in a communal dining room. Staff discussed the persons medicines with them in the presence of other people. This did not ensure the persons privacy or dignity.
- We received mixed feedback from people and their relatives. One relative said, "I am generally happy with [family member's] care, although, there does seem to be a problem with the laundry. Clothes go missing. I have known them to be wearing someone else's clothes. I have spoken to the staff, but it does still happen".

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always well supported by staff.
- Staff told us they felt their time with people was limited and they could not support people fully. One staff member said, "We try to talk to and support everyone equally but it's not always possible to engage with everyone as the home is so large".
- People were supported to lead their lives in their chosen way. The protected characteristics of the Equality Act 2010, such as age, sexual orientation and gender, were embraced rather than treated as barriers to people leading their lives in their preferred way.
- People said that although staff were rushed they were treated well. One person said, "I couldn't wish to be better looked after. I get everything I need. The staff are very good and care for me. I came in for a rest but have decided to stay I like it so much here".

Supporting people to express their views and be involved in making decisions about their care
- People were supported to express their views but felt that more could be achieved.
- People told us they were not asked for feedback from the provider, however, they felt able to express their views and their decisions were supported.
- One relative told us, "All the staff are very helpful, but they don't always keep me informed. I tend to pick things up from the staff when I'm visiting rather than being told or updated by anyone".
- People told us they felt included in their care planning. They felt staff supported them in line with their preferences and in a timely manner.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support; 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's care plans were not always personalised to ensure their needs were met.
- Care plans were not person centred or easy for staff to follow. For example, one person's personal care plan described 'wants a wash, bath or shower daily' but did not describe the level of support or detail for staff to complete this.
- People who were new to the service did not have detailed care plans in place and these had not always been shared with staff.
- Care plans did not include changes to people's care. People at risk of pressure area damage had been assessed and changes identified. However, the information was inconsistent and inaccurate meaning people were at higher risk of receiving care that did not meet their needs or requirements.
- People were not always supported to avoid social isolation. Whilst we did see some people having visits from family, interactions between staff and people appeared limited and rushed.
- We observed one person waiting for over an hour after asking staff for assistance to undertake an activity. Activities seemed to be inconsistent across the different floors of the home. For example, one person told us, "I just sit about all day". Whilst other people described completing craft projects.
- There was an activities board within the home including 'exercise classes' and a 'gentleman's club', but the manager acknowledged that these activities had ceased since the COVID-19 pandemic, but this was currently under review.
- Advance decision planning in anticipation of end of life or emergency care was not effective. The provider had failed to identify issues with the Summary Plan for Emergency Care and Treatment (ReSPECT) forms people had in place. ReSPECT forms contain a summary of personalised recommendations for a person's clinical care in an emergency. Many of the forms lacked person centred information and did not contain the required mental capacity assessments.

The provider failed to ensure that people received personalised care to meet their needs and preferences including their wishes at end of life. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 not complied with Accessible Information Standard and people's communication needs had not always been assessed or fully documented within their care plans. The manager acknowledged this and advised a full review was planned.
● We spoke to the manager about how they ensured information was accessible for all people using the service. They told us, about different communication styles in place to support people. For example, they had information in large print, or in easy read pictorial format available if required.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place. Records showed complaints were acknowledged and investigated and people and their relatives were provided with updates.
● People and their relatives knew who to talk to if they had concerns and felt the service would take appropriate action.
● A relative told us, "I have no concerns whatsoever but if I did, I would speak to the manager, they would sort it out no problem".

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- Managerial oversight of care plans was inconsistent and reviews completed had failed to identify inconsistencies we found on inspection.
- Pre-assessment information did not match peoples care plans. For example, one person on admission was stated to have full capacity with decision making however their care plan did not reflect this. The manager advised this would be reviewed immediately.
- The manager advised there was not a designated staff member responsible for assessing people and creating care plans and this had led to delays and inconsistencies. The manager stated they were looking to upskill senior members of staff to ensure accuracy of care plans in a timely manner going forward.
- The provider had cleaning schedules and audits in place, however these were not effective and not always fully completed meaning risks were not identified. The manager acknowledged the shortfall with audit processes and advised this would be reviewed as a priority.
- Quality checks and medicine competences failed to identify issues we found, meaning improvements could not be made. Where actions had been highlighted there had been no follow up action recorded and the issues had repeated. This placed people at continued and increased risk of receiving medicines unsafely.
- The home did not have a registered manager in post; however, the new home manager was in the process of applying to become registered.
- People did not know who the manager was. People said they were aware the home had a new manager but stated they had not met her. A visiting relative told us, "I found out there was a new manager recently. I overheard staff talking about it. I don't know their name though as the door still says the old managers name".
- The provider's dependency tool had not been used to effectively to reflect the required number of staff to meet people's needs. This had resulted in staff distribution throughout the home becoming inconsistent to people's needs. The manager was already aware of this and was in the process of undertaking a review of people's needs.
- The manager acknowledged daily checks, such as the managers walkaround and flash meeting with staff which are an opportunity to identify issues and gain staff feedback, were not documented or acted upon. This meant concerns around staff competency, infection control and personalised care planning were not identified or addressed.

The provider failed to ensure the quality, safety and leadership of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The manager acknowledged residents and relative meetings were not held regularly, and there was little engagement with people on a day to day basis. However, the manager had an action plan to address this and had recently sent relatives a feedback questionnaire.
- One relative told us, "The communication was better when we had the residents/relatives' meetings, you could get things sorted then".
- A person living at the home said, "we had residents' meetings before lockdown, it would be good to have them again. We could do with more going on and that's the sort of thing you can bring up".
- Professionals who worked with the service felt that staff not did have the time to spend with people to identify changes in their conditions or follow up appropriately.
- The manager had identified issues with the home since starting her role and had developed an ongoing action plan to address these issues, but acknowledged they were not aware of all the issues we had found during the inspection.
- On receiving our feedback during the inspection, the manager took steps to ensure medicines safety and arranged supervisions with staff.

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 The provider failed to ensure people's care plans contained relevant, up-to-date information and failed to ensure people received personalised care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were up to date with relevant training and failed to ensure they had enough staff to meet peoples needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people were being monitored and managed safely. The provider failed to ensure they were following infection control guidelines and best practice.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the service was being managed effectively and failed to ensure comprehensive quality and safety monitoring.

The enforcement action we took:

We issued a warning notice