Toqeer Aslam

Welcome House - The Cedars

Inspection report

2 Hartlip Hill
Hartlip
Sittingbourne
Kent
ME9 7PA

Tel: 01795843837
Website: www.welcomehouse.co.uk

Date of inspection visit:
06 October 2021
07 October 2021

Date of publication:
31 January 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Welcome House – The Cedars is a residential care home providing personal care to nine people with mental health needs at the time of the inspection. The service can support up to 26 people.

People's experience of using this service and what we found
People were not always safe at Welcome House – The Cedars. Individual risks had not been identified or clear guidance recorded to help to keep people safe. The premises and outside environment posed risks that had not been identified or action taken to keep people safe. The service was not clean and infection control procedures to mitigate against COVID-19 had not been managed within government guidance.

Accidents and incidents were not investigated and analysed to make sure lessons could be learnt and action taken to prevent further occurrences. People were not protected from harm or abuse as incidents were not always recorded or investigated. People's prescribed medicines had not been managed well as clear guidance for staff was not available to keep people safe.

People did not receive the individual support needed as staffing levels did not allow time. Staff were completing all cleaning, cooking and gardening tasks as well as their care and support responsibilities as staff were not employed in these roles. Some staff were working long hours without a rest break which put people at risk of unsafe care.

People did not receive care and support that was individual and responsive to their needs.

The systems in place to audit the safety and quality of the service were not robust or sufficient to alert the provider to concerns and issues within the service. Timely action had not been taken to address issues that had been identified within audits. Monitoring systems had not picked up areas which were identified during the inspection. The provider had not acted to ensure they had sufficient oversight of the service, placing people at risk.

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 requires improvement (report published 23 January 2020) and there were four breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns about the management of the service and concerns received from service users about their care. As a result, we undertook a focused inspection to review the

key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this 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.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Welcome House – The Cedars on our website at www.cqc.org.uk.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to: the management of individual and environmental risk, learning lessons from accidents and incidents, medicines management, safeguarding people from abuse, management of infection control, safe staffing levels, providing person centred care, CQC were not always notified of significant events and having systems and processes to effectively assess, monitor and improve the quality and safety of the service at this inspection.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Welcome House - The Cedars

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.

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.

Service and service type
Welcome House – The Cedars 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. The registered manager was absent during the inspection, so the inspection was supported by a registered manager from one of the provider's other care homes. We refer to them as 'the manager' through this report.

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 asked the local Healthwatch if they had received feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with five members of staff including the operations manager, the manager, a senior care worker and two care staff.

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 staff competency and 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 validate evidence found. We looked at staff rotas, training data, staff and resident meetings and quality assurance records. We continued to speak with local authority staff. We made a referral to the Kent fire and rescue service.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At the last inspection, the provider and registered manager had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had not been made and the provider and registered manager continued to be in breach of this regulation.

- People continued to not be supported by enough staff to meet their needs. Some improvements had been made to the numbers of staff on duty during the day. However, the improvements were not sufficient as there was no cleaner, cook or gardener employed. The large garden and patio areas were overgrown and unkempt, so people may not be able to enjoy the outside space safely. The service was not clean. Care staff were expected to carry out these roles. Staff told us people were encouraged to develop their independent living skills by helping with cooking and cleaning. However, there was no evidence this happened regularly.
- Only one member of staff was on night duty, with a member of staff on call for back up. It was a waking night duty and usually the same member of staff each night. According to staff rotas, the member of staff rarely had a day off. Over a four-week period, they did not have one day/night off until the last day of the 4 weeks. Some weeks they worked over 70 hours a week. When we raised this with the area manager, they told us they had also noticed this during the inspection. They had arranged for the staff member to have one day off after the inspection. This meant the staff member had still worked for 20 nights/days with no time off. There was a potential risk to people during the night as the only member of staff on duty had insufficient rest breaks from work.
- One member of staff on duty at night may not be able to ensure the safety of people and support the safe evacuation of the building in the event of a fire. Nine people were living at the service and rooms were spread over three levels. Some people may be too anxious to leave the premises independently and need encouragement and support from a staff member. Some people used walking aids to help them to walk around so may be slow and need the support of a staff member.
- Staff told us they thought there were enough staff. They said it would be helpful to have a cleaner and gardener, but they managed. This was not what we found. Local authority staff had visited before the inspection and had raised their concerns about staffing levels. Some people told us they did not think there were enough staff and did not feel they got enough support.

The provider and registered manager failed to ensure sufficient staff were deployed to ensure people had

the safe support they required. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At the last inspection, the provider and registered manager failed to ensure people were protected from the risks of abuse or improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had not been made and the provider and registered manager continued to be in breach of this regulation.

● People continued to not be consistently protected from the risks of abuse, discrimination and avoidable harm. Although staff continued to update their training, some staff were not confident when describing their responsibilities to report safeguarding concerns. They were able to clearly describe who they would go to with concerns within the organisation but struggled to say how they would report concerns of abuse externally.
● Incidents had not always been fully recorded and investigated. One person had made allegations against staff. The local authority safeguarding team and police had been involved and the provider had complied with their requests for information. Police visited the service due to allegations made. The visit was recorded in a 'file note', completed by the registered manager. However, the allegations referred to were not recorded as an incident and no record of an investigation was completed. The lack of investigation and monitoring meant the opportunity to learn lessons and identify appropriate support had been missed. Measures to keep people safe had not been explored. A consistent and robust approach to the recording and investigation of safeguarding concerns was not in place.
● Individual risk assessments did not provide sufficient information to protect people from potential abuse. Some people could become quite anxious at times and this would create a situation where they could be challenging and cause harm to others. One person's risk assessment said they must not be left alone in a room with other people. Although we did not observe the person in a room with others during the inspection, there was no specific guidance to advise how this could be achieved or to provide a consistent approach to keep people safe.

The provider and registered manager failed to ensure people were protected from the risks of abuse or improper treatment. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● A process was not in place to make sure lessons were learned from accidents and incidents to prevent future occurrences.
● A residents meeting in July 2021 recorded that staff had raised concerns about people smoking in the service, encouraging people not to. The record stated that it was important as, 'a few weeks ago we had another fire at the home, it was found by staff and put out quickly'. The incident was not recorded, and an investigation to find the causes, to learn lessons and inform preventative action, had not taken place.
● Although individual records of accidents and incidents were recorded, some were not. A log to create an overview of all incidents was not completed. This meant the provider could not be assured they had the information they needed to learn lessons and put plans in place to prevent further incidents.
● A local authority commissioner completed a review in November 2020. The record from the meeting

stated, 'At the last review Commissioning recommended manager keeps an overall log at the front of the incident and accident folder to assist with the indication of any issues or patterns within the home – the manager will look at implementing in the new year.' This had not been implemented.

The provider and registered manager failed to ensure incidents were recorded and lessons were learned to prevent future occurrences. This was a breach of Regulation 12 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last inspection, the provider and registered manager failed to ensure medicines were managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had not been made and the provider and registered manager continued to be in breach of this regulation.

● People's prescribed medicines were not always managed safely. Medicines prescribed to be taken 'when required' (PRN) did not always have clear guidance in what specific circumstances these should be offered to people by staff. Some people had more than one medicine prescribed to support them during an anxious episode. Protocols in place were not clear when staff should offer which medicine. Care plans and risk assessments did not include at what point PRN medicines could be offered if signs of increased anxiety were present.
● One person was prescribed a strong painkiller if their pain became severe. The person's care plan stated the medicine could be addictive, so a pain scale to measure the level of pain and a pain diary must be completed. The care plan went on to say permission must be sought from the registered manager before staff administered the medicine. Guidance did not include what staff should do if the registered manager was not available, to avoid a delay in the person accessing their important medicine. A pain diary was not always completed. Five doses were given by staff but not entered into the pain diary, a crucial part of their care plan. This had not been picked up during the registered manager's weekly medicines audit, so action had not been taken to ensure the care plan was followed.
● A record of medicine given was crossed out by one member of staff and not countersigned by a second member of staff to confirm the medicine was not given.
● Important information about some people's medicines was not available for staff. For example, medicines that had specific safety instructions about how they should be taken and when.
● People had a care plan to provide guidance to staff about what action to take if people refused to take their medicines. All care plans were very similar and did not give instruction that was individual to the person and their circumstances or level of risk. Although staff on duty knew people well, the lack of individual guidance for new or agency staff meant people were at risk of potential harm during the administration of their medicines.

The provider and registered manager failed to ensure people's medicines were managed in a safe way. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

● Two staff administered people's medicines to reduce errors. Staff carried out safe practice when they were giving people their medicines.
● The registered manager kept in touch with health care professionals to make sure people's medicines

were reviewed regularly.

Assessing risk, safety monitoring and management

● The premises and grounds were in a state of disrepair which caused many issues of safety. Windows did not have safety catches in place to restrict how far they could be opened. People were at serious risk of falling, or jumping, from the windows, which could be opened wide. An environmental risk assessment completed in April 2021 highlighted the risk. The risk assessment recorded the identified hazard as, 'Risk of falling out, suicide attempt from window'. Existing precautions and measures recorded, 'Retainers fitted to windows, monthly audits completed by manager' and 'Adequately controlled'. However, retainers had not been fitted and the risk was not controlled. The operations manager arranged for window restrictors to be fitted to all windows and this was completed after the inspection.

● Fire escape routes through the back garden were restricted by large weeds and plant pots with weeds in them. The area people used for smoking was not clean, benches to sit on were old and unstable. Large weeds were growing out of a gutter which meant rain would spill over onto the smoking area, creating a slip hazard. Outside lighting was poor, including fire escape routes and badly maintained steps down to a side garden and cellar area. Some of these areas were addressed during the inspection, however, measures taken were not a permanent solution.

● A fire risk assessment in August 2019 highlighted walking aids obstructing the fire escape route down the stairs. During the inspection, the walking aids were stored in the same area, obstructing a safe exit. Some automatic fire doors did not close fully. We made a referral to Kent Fire and Rescue Service after the inspection to check fire safety compliance.

● A chest freezer to store additional foods was stored in a cellar. Food was not stored in date order and the freezer was in disarray. Food had not been labelled to ensure it was eaten within recommended time scales. The manager asked staff to check and correctly store or discard the frozen food during the inspection. A pool of water from under an upright fridge was clearly visible on the floor and the electric lead for the chest freezer was lying in this. Staff cleared the water up and removed the fridge straight away. The operations manager told us the fridge had been disconnected the day before. Although people did not access the cellar, this had not been carried out safely and led to a potential fire and safety risk. The issue had not been noticed until we pointed it out.

● A wooden threshold within a main thoroughfare was not flush to the floor and was not highlighted to draw people's attention to it. This was a trip hazard. One person walked around the service with the help of a wheeled walking aid so this could have been a hazard for them.

● Management plans did not always provide the level of detail needed to make sure individual risks were mitigated. Some people could be verbally or physically aggressive when anxious. The guidance for staff to follow when people were showing signs of becoming more anxious, or had become challenging towards others, was generic. Guidance included asking people to go their room. Further information about how to ensure a consistent approach with the individual was not given. Some people who smoked cigarettes did not have individual risk assessments to address the physical and environmental risks associated with this, such as the risk of fire.

The provider and registered manager failed to provide safe care and treatment. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was not in a good state of cleanliness throughout. Staff were expected to complete all cleaning tasks as well as their caring duties. High touch areas such as light switches and door

handles were not cleaned regularly to help prevent the spread of infection. Deep cleaning had not taken place and cleaning records had not been completed. In a five-week period between August and September 2021, a record of cleaning completed by staff had been made only six times.

● We were not assured that the provider's infection prevention and control policy was up to date. The provider's policy and procedure contained limited information about what staff should do to prevent an outbreak, or in case of an outbreak, of COVID-19. Areas such as the policy around testing, the use of PPE, visitors, enhanced cleaning and specific training for COVID-19 were not included. The provider's audits did not include infection prevention and control or COVID-19 procedures.

● We were not assured the provider was preventing visitors from catching and spreading infections. Although we were told by the manager and area manager that visitors coming into the service were tested for COVID-19 before entering, records had not been kept to evidence this. Safety measures, such as a checklist of symptoms or temperature taking were not in place or recorded.

● We were not assured that the provider was using PPE effectively and safely. A safe place was not made available for staff to put on and take off their PPE. Only one clinical waste bin was available in the service to dispose of PPE, which required staff to touch it to dispose of their soiled PPE.

● We were somewhat assured that the provider was accessing testing for people using the service and staff. Although people and staff told us they had been tested regularly as set out in government guidance, it was difficult to determine if anyone had missed a test from the records kept.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were somewhat assured that the provider was meeting shielding and social distancing rules.

● We were somewhat assured that the provider was admitting people safely to the service. There had been no recent admissions, but we had not been assured by the provider's management of COVID-19 guidance.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

The provider and registered manager failed to ensure safe infection prevention and control practice. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

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 requires improvement. 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

At the last inspection, the provider and registered manager failed to ensure systems to monitor the quality of the service were effective. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had not been made and the provider and registered manager continued to be in breach of this regulation.

● The safety and quality of the service was not maintained and improved through robust and meaningful monitoring processes. We found many concerns during the inspection. Some of these had been picked up by the provider or registered manager but action had not been taken to keep people safe, and to provide a comfortable and good quality service for people to live in.
● During a manager's environmental audit in May and June 2021, window safety was ticked as being checked. The audit in July 2021 ticked yes for window safety but a comment was made, 'New safety catches bought for upstairs' and managers notes recorded, 'Will arrange for safety catches to be put on upstairs windows in extension'. The audits in August and September 2021 showed window safety had again been ticked and no comments made to show action referred to in July 2021 had been taken. No window restrictors were in place during our inspection. The provider's quarterly quality assurance audits had not identified this serious safety concern.
● The service had a large garden which was overgrown and unsafe in places. We were told the gardener had been absent for some months and staff tended the garden. The monthly managers audits in July, August and September 2021 indicated the garden could not be kept up due to the weather. The provider's quarterly quality assurance audit in August 2021 identified the garden needed maintaining however, this had not been actioned and other environmental concerns had not been identified.
● Monthly health and safety audits recorded every month that 'stock rotation is operating in freezers'. However, this was not the case during the inspection. Food had not been labelled with the date of freezing and this had not been picked up.
● Issues picked up in the provider's three-monthly quality assurance audits were similar across February, May and August 2021 without any action being taken. A fire, referred to in the residents meeting in July 2021 was not raised in the audit. The concerns we identified during our inspection had gone unnoticed until we pointed them out.

● There was a lack of oversight by the provider that meant issues that were clear when walking around the service had not been identified. Action had not been taken to address concerns found at the last inspection to make improvements. Conditions had deteriorated.

The provider and registered manager failed to ensure systems to monitor the safety and quality of the service were effective. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

At the last inspection, the provider and registered manager failed to notify CQC of events without delay. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection, enough improvement had not been made and the provider continued to be in breach of this regulation.

● The police had attended the service twice, on 6 and 7 September 2021 regarding allegations made against staff. The provider failed to notify CQC of this event, as required under the regulation.

The provider and registered manager failed to notify CQC of events without delay. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Records kept were not always accurate or person centred. People were not involved in the development and review of their care plans. Although a space for people to sign was included on the documents, people had not signed to say they had been involved. Staff told us only the registered manager completed care plans. The people we spoke with could not confirm they had discussions about their care.
● Some people's records recorded 'he' instead of 'she' and 'she' instead of 'he' and provided the wrong information. One person's care plan said they were independent getting in and out of the bath in one part and they needed support in another part, while at the same time referring to the wrong gender.
● Although people had a keyworker, some staff were unsure what their role entailed. Staff could tell us they spent time with people and made sure they got to appointments etc. However, they were not always aware of keyworker monthly meeting records as the registered manager completed these. This meant people did not have the full individual benefits of having a keyworker.
● People were not provided with the individual care they needed to promote confidence building and support inclusion. Staff had too many roles added to their care and support role to enable a person-centred approach. Enough staff were not deployed to make sure people received the care and attention they needed.

The provider and registered manager failed to ensure people received individual care specific to their needs. This was a breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

● Staff told us they found the registered manager approachable and felt comfortable raising any issues with them. They felt supported. Staff comments included, "I am very happy here and feel well supported. All the managers are good and approachable"; "I can go to the registered manager with anything at all and talk to her about anything. For example, if she thinks I look a bit tired, she tells me to go to sit down" and "The registered manager is a good listener, good team work here."

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

● Regular resident's meetings were held. However, the notes of the meetings did not always show an inclusive approach. Staff directed the meetings. People were told in one meeting the police would be called if they lent money to each other as this was often a source of disagreement.

● Annual quality surveys were sent to people's family and friends, health professionals and staff. The last survey had taken place in December 2020 and responses were positive. An analysis of responses had been completed with action points.

● Regular staff meetings were held which gave staff the opportunity to provide feedback about the running of the service. The registered manager took the opportunity to update staff on changes to guidance and to check their knowledge of areas of care.

Working in partnership with others; 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 and staff spoke with people's relatives to update them when necessary and they had permission to do so.

● Staff referred people to health care professionals when needed.

● The registered manager and staff worked closely with people's health care professionals, such as the local mental health team and psychiatrists, to make sure people received effective healthcare and support.

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 and registered manager failed to ensure people received individual care specific to their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to provide safe care and treatment. The provider and registered manager failed to ensure incidents were recorded and lessons were learned to prevent future occurrences. The provider and registered manager failed to ensure safe infection prevention and control practice. The provider and registered manager failed to ensure people's medicines were managed in a safe way.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The provider and registered manager failed to ensure systems to monitor the safety and quality of the service were effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to ensure sufficient staff were deployed to ensure people had the safe support they required.