Geraint House Limited

Geraint House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Geraint House is a residential care service providing personal care and accommodation to up to 11 people with mental health needs. At the time of our inspection there were 10 people using the service. Each person has a private bedroom with shared washroom and kitchen facilities separated across three floors. The care home has a dinning room, two lounges and a garden to the rear of the property.

People's experience of using this service and what we found
People were not being supported to have their 'as required' prescribed medicines safely. The provider failed to ensure people were protected from harm or abuse and there was a lack of robust safeguarding systems in place. Risk was not adequately identified or monitored, resulting in unsafe fire evacuations and people's individual needs not being met. Staff were not always recruited safely and lacked knowledge and training regarding specific health needs. The environment was worn and dirty. Infection prevention and control was poorly managed, and people were not kept safe from increased risk of contracting health infections such as COVID-19

People's needs were poorly assessed and did not inform their care plan. Care plans for newly admitted people were not robust. The provider failed to ensure staff were trained and competent to fulfil their roles. Deprivation of Liberty Safeguards were poorly managed and did not inform people's care plans. People's dietary needs were not always considered or met. The provider worked alongside external professionals; however, health information was not always used to ensure peoples' needs were met.

The provider had a significant lack of robust governance oversight and quality assurance systems in place to ensure quality of service. Care plan reviews were of poor quality and ineffective at improving care. The provider failed to adequately respond to concerns raised with them by the inspector during the inspection. People and staff had limited ability to provide feedback and input to the running of the service due to Meetings not always being held regularly in line with organisational policy. The provider failed to consistently notify the local authority and CQC when incidents or allegations of abuse were disclosed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 14 February 2020).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection prevention and control (IPC) and staff COVID-19 vaccinations as a condition of deployment. A decision was made for us to inspect and examine those risks.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

We inspected and found there was a concern with IPC risks and the use of potentially restrictive practices, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe, Effective and Well-led.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the Safe, Effective 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 Geraint House on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 identified breeches in respect of people's consent to receive care, their safe care and treatment, safeguarding people from abuse and improper treatment, the premises and equipment, the provider's governance arrangements and staffing.

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

We have sent the provider three warning notices to request improvements are made.

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.

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 provider's 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 effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Geraint House Residential Care Home

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 prevention and control measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 completed by three inspectors.

Service and service type
Geraint House is a 'care home' for people with mental health support needs. People in care homes receive accommodation and/or personal care as a single package under one contractual agreement dependent on their registration with us. Geraint House 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 a registered manager in post.

Notice of inspection
The first inspection visit to the care home was unannounced. The following three inspection visit were announced, with 24 hours' notice.

What we did before the inspection
We reviewed information we had received about the service since the last inspection.

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 visited the service on four separate dates to complete the inspection. We Inspected the environment on each site visit.

We spoke with four people using the service, one relative, the registered manager and six staff members.

We reviewed a selection of records including five people's care files and multiple medication records. We looked at three staff files in relation to recruitment and training. A variety of records relating to the management of the service, including policies and procedures were examined.

After the inspection
We continued to seek clarification from the provider to validate evidence found, and we continued to review information sent to CQC provided by the provider.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- We were not assured the provider was responsive to allegations of abuse. For example, during the inspection a person living at the service disclosed an incident to the inspector. The inspector told the registered manager, but the registered manager did not investigate the concerns or report them to the local authority safeguarding team. This meant the person had not been safeguarded from further potential harm. We raised these concerns with the provider, who then took action to report and investigate the allegation.
- There was a lack of robust safeguarding systems in place to ensure people were kept safe from harm or abuse. Some previously recorded incidents of potential abuse had not been reported to the local authority safeguarding team by the registered manager, and there was a lack of follow up action to ensure people were kept safe.
- Actions taken to safeguard people from abuse were not always effective. The provider had responded to a previous allegation of abuse and put in place additional staff monitoring. However, the guidance provided to staff was not robust, and the associated risks had not been fully considered. The person was therefore not kept safe from further risk of harm or abuse. A staff member told us this person had disclosed feeling unsafe, despite the actions taken by the provider to protect them.
- The provider failed to consistently notify the local authority safeguarding team when relevant incidents occurred, or when allegations of abuse were disclosed by people and staff.

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

Assessing risk, safety monitoring and management

- People were not safe in the event of an emergency evacuation. A fire evacuation plan was in place, however, this was not robust, as it did not provide sufficient detail to ensure people with additional needs were supported to evacuate. In addition, staff lacked knowledge on personalised emergency evacuation plans, and records indicated they were not always followed during fire drills to ensure a safe evacuation. This put people at increased risk of potential harm in the event of an emergency evacuation.
- Risks associated with people's on-going health needs were not managed safely. The provider had failed to ensure adequate risk assessments had been completed or kept up to date for specific health conditions. For example, there was a lack of guidance and risk management to ensure safe blood glucose monitoring. This meant staff were not always guided on how to meet peoples' health support needs.
- There was a lack of robust risk management related to peoples' behavioural and emotional support

needs. A review of records indicated people were not always supported in a dignified manner, and staff lacked knowledge and guidance on positive behavioural management.
● Risk at the service was poorly managed. One person who required support to access their community safely, was not protected from associated risk, due to poor quality assessments and a lack of risk foresight.

Using medicines safely
● People were at risk of being over medicated. 'As required' medicines, prescribed for anxiety, were sometimes administered as a first response to anxiety, without the use of behavioural intervention strategies. In addition, 'as required' medicines were not always being administered as prescribed, as staff were administering these medicines upon request from the person, without any indication of anxiety. This failure to administer 'as required' medicines as prescribed, put people at risk of being over medicated. This impacted five people at the time of our inspection. We raised these concerns with the provider, and they introduced an administration strategy for 'as needed' medicines, whereby staff had to seek authorisation before administering these medicines.
● There were no individualised protocols in place for the use of 'as required' medicines prescribed for anxiety. A blanket approach to the administrations of 'as required' medicines was in place and there was no individualised guidance within care plans. We spoke with staff as part of inspection who confirmed this. We raised these concerns with the provider, and they implemented individualised medication protocols.
● Medicine records were not always completed. The reasons for administration of 'as required' medicines were not always recorded. This put people at risk due to unsafe medicine management. We raised these concerns with the provider, and they made us aware of their plans to address the issue.

Learning lessons when things go wrong
● Lessons were not always learned when things went wrong, resulting in missed opportunities to improve care and minimise risk. For example, care plans and risk assessments were not reviewed in response to incidents or safeguarding allegations. This meant the provider failed to ensure care strategies were up to date and reflective of people's ongoing needs.

Preventing and controlling infection
● We were not assured the provider was preventing visitors from potentially spreading COVID-19. Visitor COVID-19 test results were not consistently checked by staff. This meant people were not kept safe from the risk of COVID-19 when visitors entered the home.
● The home was not sufficiently maintained to ensure risks of infection were minimised. Handrails and hand contact surfaces were damaged and worn, exposing porous surfaces which could not be effectively cleaned. This put people at increased risk of the spread of infectious diseases.
● Staff were not wearing appropriate personal protective equipment (PPE). At the time of the inspection, government guidance required all staff working in care homes to wear face masks, to minimise the spread of COVID-19. The provider was non complaint with this guidance and people were at increased risk of COVID-19 infection. We raised this with the provider during our inspection, and signposted them to government guidance, however, they failed to appropriately address the issue and remained non-compliant.
● Hand wash facilities were not adequately stocked to provide people and staff with the means to wash and sanitise their hands.
● Staff completed regular COVID-19 testing. However, the frequency was not completed in line with government guidance. This meant the risk of staff potentially spreading COVID-19 infection was not sufficiently mitigated.

● We were not assured the provider was making sure infection outbreaks were effectively prevented or managed. The provider failed to promptly notify the inspector, that a staff member interviewed during the inspection, had tested positive for COVID-19.
● The provider had an infection prevention and control policy, however, this was not robust and failed to ensure risks were minimised. For example, the policy did not provide sufficient detail to ensure IPC audits were effective, or that government COVID-19 related guidance was adhered to.

Medicines were not managed safely. IPC practices were poor, and people were not kept safe from infectious diseases. Risk was not adequality assessed or monitored, and lessons were not always learnt when things went wrong. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of this inspection, registered persons were required to ensure all care home workers and other professionals visiting the service were fully vaccinated against COVID-19, unless they had an exemption or there was an emergency. At this inspection, we checked to make sure the service was meeting this requirement, and identified a breach of Regulation 12(3):

● The provider did not consistently check the vaccination status of visiting professionals.
● The system in place for monitoring the vaccination status of staff was not robust.

Since we inspected this service, the Government has changed the law. There is no longer a legal requirement for care home workers and other professionals visiting the service to be fully vaccinated against COVID-19.

● The provider's records indicated regular cleaning had been taking place, but we found this was ineffective. Several areas of the care home were seen to be dirty. For example; we observed taps with black mould, a stained and dirty toilet seat, and a visibly dirty pull cord light switch. This failure to ensure effective cleaning resulted in people being at increased risk of contracting infectious diseases.
● We raised concerns with the provider regarding the cleanliness of the home. The provider responded to these concerns and told us they completed a deep clean of the home. However, when we returned to continue the inspection, we found the home still to be dirty. Therefore, the deep clean had been ineffective.
● Cleaning products were not always used for their manufactured purpose, minimising their effectiveness. For example, hand sanitiser was being used to sterilize high touch points. Hand sanitiser is designed to keep people's hands clean and has not been approved for use on high touch points in care homes.
● Floor mops were incorrectly stored, which presented further IPC risks. The inspector raised this with the registered manager who responded by purchasing disposable mop heads. However, the provider failed to update their policy to ensure staff received the necessary guidance.

The provider failed to ensure the premises and equipment were clean. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● The provider facilitated visitors to the home in accordance with government guidance. We observed evidence of external health and social professionals visiting the service and one relative told us they could visit the home if they chose to do so.

Staffing and recruitment

● Staff recruitment processes were not always robust. The provider completed identification and disclosure and barring service (DBS) checks for new staff. However, staff recruitment records showed gaps in employment history, and these gaps had not been addressed. In addition, one staff member had started employment before reference checks had been fully completed. This meant the provider could not be assured staff were suitable for their roles.

● The provider told us they had a full staff team, and during our inspection we observed suitable staff deployment.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff lacked knowledge and training on safe diabetic care and support. The service was responsible for the management of people's dietetic care needs. However, staff had not received diabetes training and lacked the knowledge required to ensure people's diabetic care and support needs were met. This meant people were at risk of poor diabetic health due to receiving care from untrained staff.
- The provider failed to ensure staff were adequately trained to meet people's mental health needs. Staff lacked knowledge on de-escalation techniques and conflict resolution. At times, situations of conflict were poorly managed, resulting in people being treated in an undignified manner. For example, records indicated people were being confronted and sent to their room during times of distress.
- The provider failed to ensure staff were competent to fulfil their roles. The provider had competency checks in place, however, these checks had not identified the related poor practice.
- The provider failed to ensure new staff were adequately trained before starting employment. Staff inductions were not always robust and new staff had started employment without completing the required training, reading organisational policies or people's care plans. This meant new staff were not adequately inducted to fulfil the requirements of their role and people were at risk of receiving support from untrained staff.

The provider failed to ensure staff were trained and competent to fulfil their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider did not have robust oversight of people subject to restrictions under DoLS. Where people were subject to restrictions, applications for DoLS had been made. However, it was not clear that where DoLS had been granted with conditions, this had been incorporated into people's care records. We observed one case where this put a person and increased risk of harm when accessing the community, as staff did not have current and accurate information about how to keep them safe.
● Staff had been provided with MCA training, however, a review of people's care records, indicated staff lacked the knowledge required to apply this to care practices. We spoke with staff as part of our inspection, and found some staff were not fully aware of their responsibilities in relation to MCA and DoLS.
● The provider sought to obtain signed consent from people living at the service in relation to their care needs and preferences, but this was inconsistent and not always up to date. This meant people were potentially not regularly consulted about their care.
● Care records did not demonstrate that people's mental capacity was being considered, or that best interest decisions were being made and accurately recorded. Based on our observations, and a review of the provider's care records, we were not assured people were always asked for consent before being supported.

The need for consent was not always considered and recorded in accordance of the Mental Capacity Act 2005, when people were receiving care and support. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The environment throughout the home appeared worn, tired, and in need of repair and refurbishment. Carpets were worn, paintwork was chipped and peeling, furniture was stained, and grab rails were damaged and unsafe.
● Garden furniture, used by people living at the service, was worn and broken, increasing the risk of potential incident.

The provider failed to ensure the premises and equipment were clean and suitable for the purposes for which they were being used. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We raised concerns regarding the environment with the provider. The Provider told us they would complete a full environmental audit and sent evidence of some maintenance repairs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Prior to people moving to the service, their needs were assessed. However, these assessments were not sufficient or robust to ensure people's needs were fully understood to enable the development of effective care plans and risk assessments. For example, assessments and care plans for new admissions did not fully consider people's pre-exiting health conditions. This meant new people admitted to the service were at increased risk of not receiving personalised care that fully met their needs.
● Assessments of people's care needs for people were very basic and had not fully explored key information such as life history, personal wishes or people's equality and diversity support needs. For example, their religion, culture, health needs and abilities.

● Care plan reviews were of poor quality and ineffective at improving people's care. The reviews failed to identify missing or incorrect information within care plans and did not demonstrate people's wishes or input regarding their care had been considered.

There was a lack a lack of robust assessment processes. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People's care plans lacked enough detail to ensure their dietary needs were met. For example; there was a lack of guidance within people's support plans to ensure their specific diabetic dietary needs were adequately considered. This put people at potential risk of developing poor health.

● Staff had created a tuck shop to enable people to have access to treats, such as chocolate and crisps, during the COVID-19 pandemic. However, there was a lack healthier options to cater for people's specific health needs.

● People were supported to have access to a varied diet. One person told us; "Dinner was very nice, I liked it."

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

● The provider worked with external professionals when new people were admitted to the service. However, they did not always take appropriate action to ensure people's needs were fully understood.

● The provider did not always follow up on information received from medical professionals when new people were admitted to the service. This meant people's health needs were not always fully understood.

● People living at the service were supported to book and attend medical appointments. This helped ensure ongoing access to healthcare services and support.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had not ensured high quality, person centred care. People's care needs were not always being met, as detailed in this report, and this had an impact on their safety.
- We found warning signs of a closed culture developing at the service. CQC defines a closed culture as being as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. Some examples of potential closed culture warning signs found during this inspection are stated throughout this report. They include; unreported safeguarding concerns and allegations of abuse; staff not being given adequate training and guidance to meet people's needs; lack of information sharing and failing to learn lessons when things went wrong.
- The provider failed to adequately respond to concerns raised during the inspection. The inspectors raised concerns with the provider in relation to staff not wearing face masks, and staff COVID-19 tests not being completed in line with government guidance. The provider took action in response to these concerns, but remained non-compliant with government guidance, and therefore, did not fully mitigate associated risk.
- There was a lack of appropriate systems and processes in place to ensure effective oversight of incident management and reporting.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- There was a lack of governance oversight by the registered person. Managerial responsibilities, and the day to day running of the service, was assigned to the care manager. However, there were no systems or processes in place to ensure effective oversight of the service by the registered manager. This resulted in shortfalls not being identified or addressed.
- Staff training was poorly monitored. There was a system in place to monitor the completion and compliance of staff training, however, this was not used effectively. The training matrix indicated staff had completed mental health and positive behaviour support training, however, there was no documentation to support this, and staff knowledge in these areas was poor. This poor monitoring of staff training meant people were at risk of receiving support from untrained staff.

● There was a lack of systems and processes in place to ensure quality of service. For example, care plans were not audited to ensure they were of good quality and relevant to people's care needs. This lack of oversight resulted in poor quality care planning that contributed to people's needs not being met.
● The provider failed to take action in response to identified risk. We raised concerns with the provider in relation to staff not wearing PPE face masks in line with government guidance. The provider responded and put in place risk assessments. However, the risk assessments did not consider the risks to people living at the service or consider government guidance. Poor risk management meant people were not kept safe from increased risks of potential harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Resident meetings were held to offer people living at the service an opportunity to provide input and feedback about the running of the service. However, the frequency of these meetings was not completed in line with the providers organisational policy, limiting people's opportunity to express their views and wishes. As part of our inspection we spoke with people living at the service. One person living at the service told us; "Not had a meeting for a long while". Another person told us; "It's going back a bit since the last meeting".
● Feedback from staff regarding management was mixed. One staff member told us they felt supported by management and able to raise concerns, another staff member did not. However, staff consistently told us the registered manager was rarely at the care home.
● The provider told us team meetings were taking place and showed us evidence of this. However, staff we spoke to as part of our inspection, were unaware of these meetings and did not have an opportunity to provide input. This indicated a lack of inclusion and information sharing from the provider.

There was a significant lack of governance oversight and quality assurance processes, resulting in poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● Although the provider worked alongside external health professionals, people's needs were not always fully understood, and this impacted the quality of their care.
● We raised concerns with the provider regarding poor quality diabetic care and management of medicines. The provider responded by seeking health advice from external health professionals and requesting medication reviews.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The need for consent was not always considered and recorded in accordance of the Mental Capacity Act 2005, when people were receiving care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were protected from abuse and improper treatment. The provider's safeguarding systems and processes were not effective.

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 Medicines were not managed safely. IPC practices were poor, and people were not kept safe from infectious diseases. Staff were not always recruited safely and lacked the required knowledge and training. Risk was not adequality assessed or monitored.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises and equipment were clean.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a significant lack of governance oversight and quality assurance processes, resulting in poor quality care.

The enforcement action we took:

Warning Notice