St Brelades Retirement Homes Limited

St Brelades

Inspection report

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Date of inspection visit:
10 May 2022

Date of publication:
07 July 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
St Brelades is a residential care home providing personal care to up to 37 people. The service provides support to people living with dementia. At the time of our inspection there were 33 people using the service. The service is a large, converted property and accommodation is arranged over two floors.

People's experience of using this service and what we found
People told us they were happy living at St Brelades. Relatives told us they felt their loved ones were safe and well cared for. However, we found a lack of strong leadership had failed to develop a culture of good dementia care and people were not always treated equally and with respect. The provider and registered manager's checks and audits were ineffective and had not identified a number of shortfalls at the service.

When people and relatives had shared their views, these had not been acted on to develop the service. Relatives told us their loved one continued to wear other people's clothes despite feedback about this. Not all the staff had been asked for their views of the service. Staff who had been asked had told the management team they did not always feel appreciated, however this had not been addressed and continued.

The registered manager and provider had not told us about all significant events at the service so we could check action had been taken to prevent them occurring again. The provider's rating was not displayed to inform people and visitors of the quality of the service.

Risks to people were not constantly managed to protect them from harm. Some risks had not been assessed and action had not been planned to mitigate other risks. People's medicines were not well managed, and some people had missed doses of important medicines. Effective systems were not in place to record medicines stocks and identify errors. Lessons had not always been learnt when things went wrong and there was a risk incidents would occur again.

Staff had not been recruited safely and robust checks had not been completed on staff's conduct in previous roles. There were enough staff to meet people's needs however, staff had not been supported to develop the skills they needed to fulfil their roles. Most staff had not completed in-depth dementia care training.

The service was clean, and people were protected from the risk of the spread of infection. One relative commented, "They handled Covid restrictions really well and made sure everyone was provided with the proper PPE. The cleanliness of the home has always been very good. The cleaners do a good enough job.''

The registered manager had applied for and obtained appropriate legal authorisations to deprive some people of their liberty.

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

Rating at last inspection
The last rating for this service was good (31 January 2018).

Why we inspected
We received concerns in relation to the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate based on the findings of 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.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Brelades 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 have identified breaches in relation to risk management, medicines, recruitment, staff skills and competency, checks and audits and gathering and acting on people's views at this inspection. We also found we had not been notified of all significant events that happened at the service and the rating had not been displayed.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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 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.

St Brelades

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
This inspection was completed by two inspectors, a specialist advisor on medicines 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
St Brelades 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. St Brelades 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
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 who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people and 13 relatives about their experiences of the service. We spoke with nine staff including the registered manager, operations manager and three care staff. We reviewed a range of records. This included six people's care records, multiple medication records and three staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits 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.

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

Assessing risk, safety monitoring and management

- Relatives told us their loved ones were safe living at St Brelades, however we found risks to people were not always managed. We observed a person calling for help and trying to stand from a chair. Risks of the person falling while standing had been assessed and staff had been instructed to intervene if the person was at risk. However, no system was in operation to alert staff of the risk.
- Another person required a nursing procedure to be completed regularly. Community nurses had delegated this task to staff. The registered manager was unable to demonstrate staff had the skills to do this competently. Risks associated with this practice had not been assessed and no guidance was available to staff. This left the person at risk of infection and distress. There was also the risk staff would not identify any problems associated with the procedure. We informed the local authority safeguarding team of our concerns. The provider stopped this procedure the day after our inspection.
- People were not robustly protected against risks associated with diabetes. Information about people's usual blood glucose levels and action to take was contradictory. It was unclear if action was needed if people's blood glucose went over 9mmols/l or 11mmols/l.
- Care had been planned for one person with epilepsy, including when to call for emergency medical care. However, staff were unable to describe what the seizures would look like and when they would call for emergency medical support. No care had been planned for another person with epilepsy. There was a risk staff would not provide the care people needed if they had a seizure.
- Regular checks had been completed on equipment. Checks on the temperature of hot water in people's bedrooms showed it was often over 44 °C. The registered manager had not identified this as a risk and action had not been taken to manage the risk of people being scalded. Other equipment was managed safely.

The registered person had failed to assess all the risks to service user's health and safety and take action to mitigate risks. The placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other risks had been assessed and action had been taken to keep people safe. Staff followed detailed guidance around moving people safely. We observed meals and drinks were prepared to the correct consistency for people who were at risk of choking.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely

● People's medicines were not always managed safely. We found one person had been given a reduced dose of blood thinning medicine three times in the week before our inspection. This had not been identified and their GP had not been informed. Blood thinners are considered critical medicines and the correct dose must be given at the right time to make sure they are effective. Following our inspection, the provider found the person had missed 19 doses. Not receiving the medicine as prescribed increased the risk of the person's blood clotting which could lead to serious health conditions, such as a stroke.

● Some people were prescribed medicated patches. The manufacturer's instructions not to reapply the patches to the same site for 14 or 28 days had not been followed to avoid skin irritation. No system was in operation to ensure the patches were applied in accordance with the manufacturer's instruction and people's skin was protected from irritation.

● A GP had increased one person's pain relief and given staff a verbal instruction to increase it gradually over three weeks. Staff had not requested the change in writing, in accordance with national guidance. The verbal instruction had been included on the medicines administration record (MAR) but not on the pharmacy dispensing label. Some staff had followed the dispending label rather than the MAR and had given the person a reduced amount of pain relief on two occasions. This left the person at risk of unnecessary pain.

● Some people received their medicines without their knowledge crushed and disguised in food, known as 'covert medicine administration'. National guidance around the covert administration medicines had not been followed. Records were contradictory about which medicines were to be given covertly. Some food and drinks stop medicines working effectively. However, guidance had not been obtained from the community pharmacist about the safe administration of some medicines. Decisions to administer medicines covertly had not been reviewed every three months in line with the provider's policy. This left people at risk of not receiving their medicines safely.

● Effective systems were not in operation to manage the medicines stocks at the service. Records of the number of medicines held in stock were incorrect. For example, one person's records showed a negative balance, however the medicine was in stock and the person had received it as prescribed. It was not possible for the provider to check medicines stocks against the records to assure themselves all medicines were accounted for.

The registered persons had failed to ensure medicines were safely managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People were not protected by safe recruitment practice. Checks had not been completed on staff's conduct in previous care roles to ensure they had the skills and experience to meet people's needs. The staff member completing the recruitment process was not aware the provider was required to complete these checks. They had obtained a reference from one staff member's partner rather than their employer. No

attempts had been made to contact other staff's previous employers for references.
● Disclosure and Barring Service (DBS) checks had been completed for most staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, a DBS check had not been obtained for one staff member and the provider had relied on a check completed by a previous employer. The provider and registered manager had not identified the staff member had not included this position in their employment history or checked their conduct in this role.

The registered persons had failed to complete robust checks of staff's conduct and experience in previous social care roles. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found people were at risk because staff had not been supported to develop the skills they needed to fulfil their role. Most staff had not completed in depth dementia training, which is essential at a service for people living with dementia. Staff had not completed other training to meet people's needs, including catheter care and epilepsy. Relatives told us they thought staff had the skills they needed.
● We observed some staff supporting people with their meal. One staff member put a person at risk of choking when they tried to put a spoon full of food in their mouth while the person was chewing. The person looked distressed and pulled their head away. We observed another staff member pull a person's legs to move them in their chair, rather than moving the chair. There was a risk of injury to the person's legs and skin.
● Staff administering medicines had completed training. However, their competency to administer medicines had not been assessed every six months in line with the provider's policy. The provider had introduced a new electronic medicines administration records (EMAR) in March 2022. Staff's competency to use the system had not been assessed and their lack of skills in its use had not been identified.

The registered persons had failed to deploy suitably competent, skilled and experienced staff to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's needs. Relatives told us, "I do think there are enough. I always see the staff with the residents'' and "From what I have seen I think there are enough staff, but I don't see the whole of the Home. Mum does have a call button in her room and if she needs help, I think she can get it fairly promptly.''

Learning lessons when things go wrong
● Effective action was not always taken to learn lessons when things went wrong and prevent them from occurring again. In October 2021 one person ate food containing another person's prescribed medicine. Robust action had not been taken to ensure this did not occur again. Guidance about the administration of covert medicines was not clear and specific. No checks had been completed to ensure staff were administering covert medicines safely.
● Before our inspection we received information that staff were taking people's medicines out of their original packaging and leaving them in pots with their names on. This increased the risk of people receiving the wrong medicines. We contacted the provider who told us they were aware of the practice and had told staff to stop. They also told us there had been a further incident of this practice. No further action had been taken to ensure staff were always following safe medicines administration practices.

The registered persons had failed to operate effective systems to assess, monitor and mitigate health and

safety risks to service users. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Effective action had been taken after other incidents and they had not occurred again. For example, the key code had been changed and staff reminded to make sure the door was secure, when a person left the service without staffs' knowledge. One relative told us, "They could not have done more than they are doing. They have coded doors, so no-one can get out". Accidents and incidents had been analysed to look for patterns and trends. Shortfalls in recording had been identified and staff had received further training and support.

Systems and processes to safeguard people from the risk of abuse
● People were not consistently protected from the risk of abuse. Some care staff had not completed safeguarding training. One staff member was not aware how to blow the whistle outside of the service. Other care staff were aware they could raise concerns with the local authority, police or CQC.
● Other staff who came into contact with people as part of their role, such as housekeeping staff, were not required to complete safeguarding training. It is important all staff have the skills to recognise safeguarding risks and know how to report them, to keep people as safe as possible.
● Care staff we spoke with knew how to identify the signs of abuse and would raise this with team leader or manager. They were confident action would be taken to keep people safe. The registered manager had notified the local safeguarding team about potential abuse so the concerns could be investigated.

The registered persons had failed to protected service users 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.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● 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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● People received visitors when they wanted in their bedroom or a specific visiting area. There were no restrictions on the length or number of visits. However, visitors told us they were required to show evidence of a negative Covid-19 test before they entered the service and had to wear a face mask. This was not in line with government guidance, which states only visitors who are providing personal care are required to complete Covid-19 tests.

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 good. 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

- There was a lack of leadership at the service. Staff told us the registered manager was not a strong leader and our findings supported this. The provider and registered manager had not developed a culture of good dementia care based on recognised best practice. Mealtimes were not planned to support people effectively. At lunchtime we observed people sitting for a long time before they received their meal. Some people left the dining table before they had eaten. We would expect mealtimes to be planned to ensure people had their meal promptly.
- Staff cared for people and did their best, however they had not been supported to always offer people dignified and respectful care. One person was distressed because their trousers would not stay up. They showed us the elastic in the waist band had gone. We told the registered manager who said they person had six pairs of new trousers. However, staff had not supported the person to wear these when assisting them to get dressed.
- The provider and registered manager did not have the required oversight of the service. A member of the leadership team told us they had raised concerns people were not treated equally but no action had been taken and poor practice continued. People used lounges dependant on their needs rather than their choices. People who needed additional support were isolated in one lounge where they spent their day. Staff told us there was not enough room for them to go to the dining room, despite one dining room not being used.
- We observed one person in their bedroom calling out for help on several occasions. Staff told us the person preferred not to be with others. They had not considered leaving the person alone in a room with nothing to do may cause them to be distressed and anxious. At mealtimes staff had not been deployed to provide the individual supported people needed. Staff did their best to support everyone but this meant people's meals were interrupted.

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

- Services that provide health and social care to people are required to promptly inform us of important events that happen in the service. This is so we can check appropriate action had been taken. The registered manager was unclear about what they were required to notify us of and told us they were "learning". They had not notified us of one allegation of abuse at the service. There had been a delay in another notification being submitted.

The registered persons had failed to notify CQC of allegations of abuse without delay. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● It is a legal requirement that a provider's latest CQC inspection rating is displayed at the service. This is so people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not displayed the rating at the service. The registered manager told us the rating had been displayed, but people regularly took it down. They had not acted to ensure it was always displayed. During our inspection the operations manager took action to make sure the rating was conspicuously displayed on the provider's website.

The registered persons had failed to display at least one sign showing the most recent rating by the Commission that relates to the service provider's performance at those premises. This was a breach of regulation 20A (Requirement as to display of performance assessments) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team did not work together cohesively to lead the service. There was a lack of clarity over who was responsible for what and no oversight of delegated tasks such recruitment, training and medicines management. The registered manager had taken on new responsibilities when the ownership of the provider company changed in 2018. The provider had not checked the registered manager had the skills to fulfil their role or supported them to develop. Following our inspection, the operations manager told us they would spend more time at the service supporting the registered manager.
● Staff told us they did not always feel supported by the registered manager. They said it was difficult to plan their life outside of work because the registered manager did the rota weekly and they had little notice of when they would be working. One staff member described the registered manager as, "A lovely person" and "not interested at times". Other staff told us the registered manager had supported them with recognised qualifications but was slow to resolve issues.
● Staff morale was low and staff did not feel appreciated by the registered manager or provider. For example, they told us they were not thanked for covering vacant shifts. The provider had given all staff a bonus but those who had gone over and above during the pandemic did not feel this had been recognised.
● People were not protected by robust policies, processes and equipment. The provider had introduced electronic medication administration records in March 2022. They had not updated their medicines management policy and guidance to reflect this change. Staff told us they felt the implementation had been 'rushed' and there was insufficient ongoing support and training. One staff member told us, "We need more support and training". Staff accessed electronic care records on their personal mobile phones as the equipment provided was ineffective.

Continuous learning and improving care
● People were not protected by robust checks and audits of all areas of the service. Checks and audits completed had not been effective and the registered manager was unaware of the significant shortfalls in quality and safety we found. The provided and operations manager visited each month but did not review checks and audits completed as part of their visit.
● Medicines audits left people at risk because they had not identified errors and poor practice. Checks were not detailed, robust and did not cover all areas of medicines management. The provider and registered manager had not reviewed and amended medicines checks following the introduction of electronic medicines administration records.
● The provider and registered manager did not audit staff recruitment processes to ensure they had all the information they needed to make safe recruitment decisions. They were aware staff training was not up to

date, but robust action had not been planned to address this.
● The provider had a development plan in place which they reviewed regularly. However, this was not based on the outcome of quality assurance checks on all areas of the service and did not include the shortfalls we found during the inspection.

The registered persons had failed to operate effective systems to assess, monitor and improve the quality and safety 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; Working in partnership with others
● People, their relatives and staff had not been fully involved in making decisions about the day to day running of the service. Feedback received had not always been used to improve the quality of the service people received. Other stakeholders such as visiting professionals had not been asked for their views of the service.
● A decision had been made to change mealtimes at the service in October 2021. This had been to maximise staff deployment. People had not been consulted about these changes, so their views could be understood and considered when making the decision.
● Relatives had been asked for their views and these were mainly positive. However, concerns had been received around the management of laundry. Effective action had not been taken and the concerns continued. Eight relatives told us they had seen their loved one wearing someone else's clothes or found other people's clothes in their bedroom. One relative said, "I have found her on occasions wearing other people's clothes. A couple of weeks ago I found twelve items of clothing in her wardrobe which were not hers".
● Some staff had not had the opportunity to share their views of the service. 10% of staff responded to a survey in July 2021. The registered manager told us only some staff had been asked for their views by mistake. They planned to ask all the staff for feedback when they next completed the process. They had not considered rectifying the mistake when they identified it. Staff feedback received had included not feeling valued and appreciated. Effective action had not been taken to address this and staff continued to feel the same way. Staff had not been asked for their views at staff meetings.

The registered persons had failed to seek and act on feedback from service users, their representatives and staff, for the purposes of continually evaluating and improving the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some relatives were confident to raise any concerns they had with the management team and told us these had been addressed. Their comments included, "I have not had to raise any concerns or complaints. If we did have to, we would discuss this and arrange a meeting with the managers, as they are very approachable'' and "When I have had a couple of concerns, these have always been dealt with satisfactorily.''

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
● People's relatives told us they were informed promptly of any changes in their relative's needs, including any accidents. Their comments included, "If there is ever anything wrong, they will telephone and tell us" and "They are always letting us know what is going on. They have always been really good in the communication and information the give us''.

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 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify CQC of allegations of abuse.

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 registered persons had failed to protected service users from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered persons had failed to complete robust checks of staff's conduct and experience in previous social care roles.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered persons had failed to at each premises at least one sign showing the most recent rating by the Commission that relates to the service provider's performance at those premises.

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 registered persons had failed to ensure medicines were safely managed. This placed people at risk of harm. The registered person had failed to assess all the risks to service user's health and safety and take action to mitigate risks. The placed people at risk of harm.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to operate effective systems to assess, monitor and mitigate health and safety risks to service users. The registered persons had failed to seek and act on feedback from service users, their representatives and staff, for the purposes of continually evaluating and improving the service. The registered persons had failed to operate effective systems to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to deploy suitably competent, skilled and experienced staff to meet people's needs.

The enforcement action we took:

We served a warning notice.