Chapel House Ltd

Chapel House

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 caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Summary of findings

Overall summary

About the service
Chapel House is a residential care home providing accommodation and personal care for up to three children and young people with high levels of support needs linked to mental health conditions. At the time of the inspection three young people lived at the service.

People's experience of using this service and what we found
Risks associated with people's behaviours were not managed safely. People who used the service and staff were placed at risk of harm. Opportunities to learn from incidents had been missed. People were subject to restrictive interventions that did not respect their rights. Not all staff had training in the safe management and administration of medicines

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. The provider was not following proactive best practice models to reduce the need for restrictive interventions. We have made a recommendation that the provider refers to national and best practice guidance to reduce the use of restrictions and restraint.

There was a risk people may receive care and support from staff who did not have the necessary skills and competency to support them effectively. Staff did not always receive support and supervision. Further work was needed to ensure the environment met people's needs. People had enough to eat and drink and their physical health needs were met.

Peoples choices were not always respected. Changes in the staff team had a negative impact on the development of trusting relationships. People's right to privacy was not always respected. The approach to building people's independence was inconsistent.

We found systems and processes used to ensure the service was running safely were not effective. We observed a lack of leadership, direction and oversight.

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

Rating at last inspection
This service was registered with us on 11 September 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the care people were receiving. A decision was made for us to inspect and examine those risks. As a result, we undertook a comprehensive 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, effective, caring, responsive and well-led sections of this full report. We took immediate action to inform stakeholders and commissioner of the severity of our concerns and continue to work closely with them to evaluate and monitor the location.

You can see what action we have asked the provider to take at the end of this full report.

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 safe care and treatment, safeguarding, staffing, need for consent, fit and proper persons and good governance 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.

Special Measures
The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their 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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Chapel House

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
Chapel House 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return 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 about their experience of the care provided. We spoke with seven members of staff including the provider, the manager and care workers.

We reviewed a range of records. This included two people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We had a meeting with the provider on 20 July 2021 to discuss the findings of the inspection so far and to inform the provider of actions we would be taking.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

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

- People were not safe and were at risk of harm. During the inspection one person told us, "I am not safe here. I don't want to be here, and I feel unsafe. If I don't get moved, I would rather run away."
- Staff did not always recognise or report abuse. We found many examples of incidents the provider should have reported to the local safeguarding authority and CQC but had failed to do so.
- We identified that during the months before our inspection many safeguarding incidents had occurred at the home. The provider had no oversight or awareness and some of these were very serious and people had been harmed.
- There was a safeguarding policy in place at the service which was out of date. Not all staff had safeguarding training.

Systems to safeguard service users from abuse were not robust enough to demonstrate safety was effectively managed. 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.

Following the inspection, we met with the provider to discuss our concerns about the service and to ask them to take immediate action to safeguard people and to ensure people were not a risk of harm. Following our inspection, we made referrals to the local safeguarding authority and further referrals to partner agencies to ensure that people were safeguarded appropriately from harm.

Assessing risk, safety monitoring and management

- Risks were not always identified or managed in a way that kept people safe. For example, one person's physical behaviours that challenge had not been risk assessed. This put the other people they lived with at risk of harm as their safety had not been ensured.
- A significant number of staff were not trained in NAPPI (Non-abusive psychological and physical intervention) which put people at risk of harm as staff were using restraint without appropriate training or updates.
- A recent incident identified several shortfalls. It was unclear what immediate action had been taken to reduce risk or to address the root cause of issues.
- For example, records showed physical interventions regularly failed to be effective with one person. Despite this, their support plan did not provide guidance of what to do if physical intervention was not effective in de-escalating situation. Support plans did not provide guidance on how to support the person more proactively and reduce the need for physical intervention. This had led to risk not being managed safely. During a recent incident where physical intervention did not work the person was able to cause harm to themselves. This lack of guidance placed both people and staff at risk of harm.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider sent us evidence that staff were being trained in positive behaviour support and the use of physical restraint as a last resort. We also asked the provider to do an immediate review of people's risk assessments.

Learning lessons when things go wrong
● Accidents and incidents were not recorded consistently.
● The provider did not complete any analysis of accidents or incidents in order to learn from these events or identify necessary actions to improve safety. This limited the provider's ability to effectively manage the risks to people.
● We found many incident records had not been effectively reviewed or acted upon. For example, records documented a recent incident where a person had caused damage to property after becoming agitated. There were no 'lessons learnt' documented on the incident form and no actions recorded to prevent similar incidents happening again.

The provider had failed to analyse accidents or incidents to learn from these events or identify necessary action to improve safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicines were not managed safely.
● Staff involved in handling medicines had not received recent training and an annual review of their knowledge, skills and competencies relating to managing and administering medicines.
● The audits carried out to ensure the safe management of medicines were not sufficiently robust and were not designed or completed in a way that would effectively identify and address any issues.

We found no evidence that people had been harmed, however, the risks associated with medicines were not effectively managed because there was not a robust auditing system in place to monitor the safe management of medicines. This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Each person had a medication administration record (MAR). This should be signed and dated every time a person is supported to take their medicines. We checked two MAR charts and found each had been fully completed.

After the inspection, the provider ensured the appropriate staff were trained and assessed as competent to support people with their medicines.

Preventing and controlling infection
● The provider was not preventing visitors from catching and spreading infections.
● The provider was not using PPE effectively and safely.
● We were not assured that the provider was accessing testing for people using the service and staff.
● The provider was not promoting safety through the layout and hygiene practices of the premises.
● The provider was not making sure infection outbreaks can be effectively prevented or managed.
● The provider's infection prevention and control policy was not up to date.

● The provider was not facilitating visits for people living in the home in accordance with the current guidance.

The provider had failed to ensure effective infection and prevention control measures were in place. This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Safe recruitment practices were not followed.
● The necessary steps had not been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal record checks were not undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions.

The provider had failed to ensure recruitment procedures were operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider sent us evidence that staff would not be able to work at the service until the necessary pre-employment checks were completed.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

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

- People's rights under the MCA were not protected as the Act had not been applied to ensure decisions were made in people's best interests.
- Where people lacked capacity, there was not always evidence of a best interest decision being made. When a best interest decision had been made this had not been documented in the person's support plan and there was not always evidence of people who know the person being involved in the assessments and decision-making process.
- Some people had restrictions on their liberty which had been appropriately authorised under the DoLS. However, we found this was not the case for all restrictions in place. For example, one person's clothes and personal belongings were kept locked away in a shower cubicle. There was no evidence recorded that this was in the people's best interests.

People were being restricted in areas where restrictions were not necessary, and reviews of restrictions were not taking place. This meant that people's freedoms and choices were unnecessarily restricted. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider sent us evidence that restrictions placed on people were being reviewed.

Staff support: induction, training, skills and experience
● People were placed at risk of harm as staff did not always have the skills or guidance to respond appropriately in risky situations.
● Support was not given to staff to direct and lead them to work as a team and drive improvements. Inexperienced and untrained staff were left in vulnerable positions without the correct number of adequately trained staff to carry out their role.
● Incident records documented several occasions where people and staff had been exposed to the risk of harm or where they had sustained actual harm. Records did not clearly evidence what action had been taken to reduce these risks to staff. This exposed people and staff to the risk of physical harm and emotional distress.
● Staff did not have an effective induction before starting to work at the service. Some staff and agency staff had not worked at the service long enough to get to know people living with complex needs.
●The provider did not provide supervision and appraisal in line with their own policies and procedures. We were told that staff had not received a supervision or appraisal since working at the service.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure there were enough sufficiently skilled and competent staff deployed to meet people's needs.

The provider responded immediately during and after the inspection. They confirmed all staff were going to receive training in areas such as positive behaviour support. They also agreed staff would not be able to work at the service until they had the necessary training and experience to support people safely.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The management team had not completed a detailed assessment before each person started to use the service to ensure they were able to meet their needs care and support needs. Assessments were either not completed or limited in detail.
● People's care plans were not updated following changes in people's needs. This meant that staff did not have access to up to date information about how to support people.
● Staff failed to understand people's needs and there was a lack of understanding regarding best practice when supporting people who displayed behaviours that challenged others. We were told of examples where staff used physical interventions to restrain people when other less restrictive measures should have been tried.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Consideration had not been given to the complex needs of people living in the premises.
● People's support needs meant that there were a lot of staff in the service and areas of the service such as corridors, the kitchen and the entranceway were not fit to accommodate a large amount of people. This had a negative impact on people who found busy environments difficult to live in.
● There was no private space to support people during times of distress and support people to de-escalate situations they found difficult.

● The premises needed some immediate re-decoration. There were numerous holes in the walls, and this was particularly noticeable for one person's bedroom. The service looked very faded and needed redecorating.

The premises were not suitable for the purpose 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.

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

● Care was not always suitably assessed, and care was not delivered in a person-centred way.

● We found one person had moved into the services without the provider first checking if they were compatible with the people already living there. They told us there had been daily conflict between people which left them being upset and afraid. We asked to provider to inform the local authority safeguarding team about this and take immediate action to reduce the risk.

● Restrictive interventions were being carried out with a number of people and there were no restrictive intervention reduction plans in place. The lack of person-centred meant that people were exposed to the risk of unnecessary control and restraint.

The provider did not follow national and best practice guidance to reduce the use of restrictions and restraint. This meant people were at increased risk of harm. This was a further breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommend the provider refers to national and best practice guidance to reduce the use of restrictions and restraint.

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

● People had enough to eat and drink. Health information was not easy to find in people's care records. This meant staff may not be able to find important information about people's health when they needed it

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

●The providers policies and procedures said they promoted inclusion, equality, diversity and human rights. However, this did not always translate into their everyday practices and documentation. For example, lack of mental capacity assessments meant it was difficult to see how human rights had been fully considered.

● Staff did not always know about people's histories and preferences.

● Some staff showed compassion and kindness. However, the provider did not ensure staff consistently provided care and support in a compassionate and supportive way. One person said, "They [staff] are horrible, and they talk horribly about the people here. I heard the manager say (about a female resident) that they are annoying as they follow them around all the time. I worry what they say about me."

● In contrast we observed caring interactions between staff and people. For example, we saw one person was extremely anxious about an incident with another service user at the service. In an attempt to distract and reassure the person the staff member was laughing and joking with the person and talking about a walking trip they had planned. The person was clearly reassured by this and it reduced their anxieties.

Supporting people to express their views and be involved in making decisions about their care

● People were not always involved in decisions about their care.

● There was very little evidence of people's voice or involvement in the day to day running of the service.

Respecting and promoting people's privacy, dignity and independence

● People's dignity was not always respected. One person's clothes were kept separately from their bedroom. Their bedroom contained only a mattress and a pillow. This person's clothes were kept in a staff toilet. The persons clothes were stored in a plastic bag in a shower cubicle. This did not respect the person's dignity.

● Peoples choices were not always respected. Changes in the staff team had a negative impact on the development of trusting relationships.

● People's right to privacy was not always respected.

● Information about people was not always kept confidential. We saw sheets in communal areas which held people's personal information.

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- People did not receive person-centred care which met their needs and preferences.
- Observations of the staff supporting people and the way in which people acted showed that people were anxious for a large majority of the day during our inspection.
- Care records we saw did not contain enough detail to ensure care was delivered in a consistent way and in line with people's choices and preferences. Care records did not reflect people's care and support required.
- People's care plans were not updated, reviewed or evaluated effectively to ensure people's needs were met safely. We found instances where there was key information missing from people's care plan which was essential to support them.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- We found these standards were not always followed. There was lack of information in a format that people could understand. For example, the care plans were not easy to read.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to go out into the community
- One person was supported to go out on their daily run and then had planned to go shopping whilst we were there. Another person was showing us how they had set up a business selling things they had made. However, in contrast another person told us," I haven't been outside for four days. They won't let me out. It is horrible."

Improving care quality in response to complaints or concerns

- The service had a complaints policy, but this was out of date and needed reviewing.
- There were no records of complaints having been made.

End of life care and support

- People were not being supported to make plans for the end of their life at this inspection.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There had been a lack of leadership, direction and oversight. The lack of leadership had impacted on the care people received. No member of the management team had day to day oversight of the service and the culture within the service was not reviewed.
- During the inspection, we found multiple breaches of regulation. These failings demonstrated the systems to assess, monitor and improve the service were not sufficiently robust.
- Medicines audits had not always been completed regularly to identify errors, concerns and areas for improvement.
- There was no effective system for analysing, investigating and learning from incidents. This failure to conduct effective analyses of incidents meant opportunities may have been missed to identify ways of preventing future incidents. This meant there was a risk people could be exposed to risk or potential distress or harm.
- The provider did not ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of the service.
- The provider did not have effective recruitment procedures to ensure that staff were of good character and had the appropriate qualifications, skills and experience for their role
- Records of care and support were not accurate or up to date and staff did not always have access to clear information about the people they were supporting. The failure to ensure complete and contemporaneous records meant we were unable to identify if people had received the care and support, they required.
- The provider understood they had to ensure that the legal requirements were met. However, the extensive nature of the breaches of the Regulations we have identified, along with the widespread and significant impact of these, demonstrated a failure of leadership and good governance.
- The provider was transparent and open about the concerns at the service. However, they had not taken sufficient and timely action to prevent people and staff from the risk of unavoidable harm.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed an action plan detailing

actions taken and planned to make improvements and reduce risk.

We took immediate action to inform stakeholders and commissioner of the severity of our concerns and continue to work closely with them to evaluate and monitor the location.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Care was not person centred and people were not always cared for in a safe way.

● Leaders in the home did not intervene or guide staff to ensure people received more appropriate care that met their personal needs.

●Through our observations and from speaking with staff, people who used the service, we could evidence that a closed culture had developed within the service. This meant people were not always able to speak up for themselves. Restrictive practices were being used, and management and staff make choices for people which are not always in their best interest.

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

● People we spoke with told us that communication with staff was poor. They told us they did not feel informed or involved in decisions about their care.

●There was a lack of evidence to show how people and their representatives had been involved in care planning.

●There was limited evidence in records people being regularly consulted about their views wishes and feelings.

Continuous learning and improving care

●The service did not promote a system of continuous improvement and learning.

● Incidents that occurred were not monitored in a way that would identify trends and patterns to prevent them from happening again.

Working in partnership with others

● The provider and the manager responded to the concerns we found on inspection. However, they did not always provide and respond to our concerns in a timely way.

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 11 HSCA RA Regulations 2014 Need for consent People were being restricted in areas where restrictions were not necessary, and reviews of restrictions were not taking place. This meant that people's freedoms and choices were unnecessarily restricted. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The risks associated with medicines were not effectively managed because there was not a robust auditing system in place to monitor the safe management of medicines. This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure effective infection and prevention control measures were in place, which is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP

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 Systems to safeguard service users from abuse were not robust enough to demonstrate safety was effectively managed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure recruitment procedures were operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

NoP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This was because the provider did not have effective systems in place to give staff appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties.

The enforcement action we took:

NoP