Mrs B J Owens

Regent 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Regent House is a residential care home providing accommodation and personal care for up 23 people with mental health needs. At the time of the inspection 7 people needed support with personal care.
Regent House is made of 3 floors, on the ground floor you will find living spaces such as two lounges, kitchen, dining room and office, with a courtyard garden. Bedrooms and bathrooms can be found on the first and second floor.

People's experience of using this service and what we found
People were put at risk of harm due to the lack of safeguarding processes and effective systems in place to implement improvements where risks had been identified.

Care plans and risk assessments did not always correlate and identify fundamental information to ensure people were supported in a safe way.
People did not always receive their medicines in line with the prescribers' instructions. There was a lack of staff trained to administer medicines, which had an impact on delivery of care.

People did not always get the dedicated support when needed. This meant people were not always provided with safe support and were unable to experience new things or meet their aspirations.

People were not always 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.

People did not receive support that was person-centred and gave them autonomy in their life. Support did not focus on people's quality of life or follow best practice.

Staff told us and records confirmed staff did not have adequate training which meant there was not enough appropriately skilled staff to meet people's needs.

The management team did not always offer the support and leadership required for the staff. Staff felt there was a lack of communication between staff and management.

The management team did not have robust governance system in place, some spot checks were in place, however, these were not effective and did not identify the issues we found.

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 (published July 2017)

Why we inspected
We received concerns in relation to safe care and treatment of people and ensuring there was enough skilled staff to meet people's care needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, lack of person-centred care, inadequately skilled staff, poor environment and lack of governance systems and management oversight.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added at the bottom of the report.

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? 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**

Regent 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 Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 1 inspector and 1 medicine inspector.

Service and service type
Regent House is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Regent 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We 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 7 people who used the service and 1 relative about their experience of the care provided. We spoke with 9 members of staff including managers, senior support workers and support workers and 5 stakeholders. We spoke with 6 professionals who were involved in the support for people and visited the service. We reviewed a range of records. This included five people's care records and numerous medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also 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; Learning lessons when things go wrong

- People were not kept safe from avoidable harm because staff were not always confident on what to look out for or recognise where people were put at risk of harm.
- People were not supported safely with fire risks. There was inadequate fire risk assessment and personal evacuation plans (PEEP) to support people to exit the property in the event of a fire. At the time of the inspection there was no record of a fire evacuation drill being completed.
- Risks such as locked fire exits, inadequate fire doors and fire risk assessment put people a significant risk in the event of a fire. We asked for immediate assurance from the Registered Manager.
- Staff were not confident in how to evacuate all people safely, particularly where people had reduced mobility. We found that only 18% of staff were trained in fire safety. We asked for urgent assurances to ensure people would be safely supported in the event of a fire. When reviewing the evidence supplied to us by the Registered Manager and speaking to staff about their knowledge of fire safety, we still could not satisfy ourselves that people would be safe. This meant people continued to be at risk of harm.
- There was a lack of assessment in the environmental and equipment-related risks. For example, there was a known risk for some people living in the service that may have a risk of self-harm. They had not assessed the environment to ensure risks for these people were mitigated.
- People's risk assessments were not clear or coordinated with the information stated in the care plans. There were several examples where we saw risks had been identified but records did not adequately demonstrate the support provided to people to mitigate these risks. One example being where someone had been assessed as needing support with their skin integrity, the risks were not managed appropriately. Another example where a person had a risk of choking, their risk assessment did not detail how to support them in the event of choking. When speaking with staff they were unable to confidently say what action they would take. This placed people at the risk of harm.
- Staff could recognise signs when people experienced emotional distress. However, they did not always know how to support them to minimise the risk to them and other people to keep them safe. During incidents staff did not follow the correct plans as staff did not always use the correct strategies. This put staff and people at risk.
- People gave mixed views about the support they received, some people said they felt safe living there however, other described feeling "frightened" and "not safe".
- There was a lack of shared lessons learnt with the whole team and the wider service. Where safeguarding's and risks emerged, the management team did not gather the information relating to accident and incidents and did not effectively look at the overall trends and themes. This meant the management team and staff team were not able to learn from these.

Using medicines safely

● People did not always get their medicines as prescribed. Records on the electronic medicine administration record (EMAR) identified gaps in administration. For example, some people were prescribed regular pain relief, and this had not need administered in line with the prescribers' instructions. As this prescription was due to ongoing health concerns to reduce the risk of pain, the lack of medicine meant people were put at risk of unnecessarily discomfort and pain.
● Staff failed to administer medicines safely. Staff were not following both national guidance and the providers medicines policy when administering controlled drugs (medicines subject to strict legal controls around use and record keeping). They did not ensure witnesses were countersigning records to show that the medicines were being administered as prescribed.
● Medicines risk assessments and care plans were missing for some people. For people who were prescribed medicines with additional physical health risks the service had not identified or monitored people to ensure they were kept safe. When speaking with staff they were unable to describe these risks.
● When PRN medicines were administered staff did not always record the reason for administration or if it had been effective. Where a variable dose was prescribed staff did not record the quantity of medicines they had given.
● Staff were not adequately trained to support people with their medicines, with only 1 staff member in date with their medicine's awareness course. The registered manager responded to this and put staff on training, however following this training we spoke with staff about specific medicines and what adverse effects to look out for and they were still unable to confirm. This meant we could still not be confident that staff had the right skills.

Preventing and controlling infection
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were not assured that the provider was admitting people safely to the service.
● We were not assured that the provider was responding effectively to risks and signs of infection.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were not assured that the provider's infection prevention and control policy was up to date.

The provider had failed to ensure they had robust systems to demonstrate safety was effectively managed, this included medicine management and risk management. This put 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
● The Registered Manager failed to operate a safe recruitment process; we found appropriate checks were not undertaken to help ensure staff were suitable to work at the service. We found examples where staff had started working at the service without adequate DBS check or risk assessments to mitigate the risk where they were still waiting for some initial documentation. This meant we could not be assured that staff were suitable for the role they had been recruited to.
● The Registered Manager did not ensure that they regularly reviewed the staffing level and skills to make sure that it was able to respond to people's changing needs.
● People said there were times where they had to wait for support or that they could not go out of the service because of the lack of staff. We observed where people called for help and there was a delay in a response. People shared they felt ignored and staff did not always respond promptly to help with their

personal care needs. We observed a conversation where someone requested to go out, the staff member said they would support that afternoon; however this did not happen. We reviewed the persons records over the following week and the person remained in doors and did not go out.

The provider had failed to have robust recruitment processes to ensure there were suitably qualified, competent and skilled staff where recruited. This put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Systems and processes to safeguard people from the risk of abuse

- People were not supported to raise safeguarding concerns; People spoke about safeguarding concerns and there was no evidence that appropriate action had been taken.
- Staff were not up to date with safeguarding training and did not follow service or local procedures when required. Staff did not recognise or respond appropriately to abuse, some staff have raised concerns to the management team in the past without appropriate action taken.
- People were not always supported in a respectful way; we observed staff responding to a person in distress in an inappropriate manner. People described interactions with staff could be "catty", "aggressive", "angry" and "feeling of being ignored." People said this made them feel upset. People said they had raised this but had not seen any change in how some staff interact with them.
- We were given examples of where staff controlled and restricted choices and rights as form of a "sanction". For example, people and staff told us, where cigarettes were kept in the office and when people ask for this staff would delay giving this as a "sanction" for a previous interaction.
- Another example given was where people would not be given their meals promptly because the staff said the person "could wait" due to an incident. This could expose people to significant psychological harm and distress.

The provider failed to ensure they had robust systems in place to protect people from abuse. This put people at risk. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment)

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Care plans were not always clear and coordinated with risk assessments and lacked important information relating to people's support. Although, the manager had started to develop the documentation. This meant staff could not be confident they were providing the right support for people.
- Care and support plans failed to reflect people's aspirations and future goals or focus on people's quality of life outcomes. This was evident when observing staff taking an active role in people's day to day life and not encouraging independence. One person said, "I would like to do things for myself." Another person said, "I would like to do some cooking." There was no evidence that staff had taken this into consideration to meet peoples' requests.
- People's social needs were not always met. Peoples said they lacked the opportunity to go out as they wanted to, records confirmed this. One person said, "There's not much to do, going to the town and do shopping, when I am able to."
- People were not always supported to make referrals for appropriate care and treatment at the right time, we found a recommendation made by a professional for a person with underlying health conditions to see a chiropodist. Records showed this was not actioned until 8 months later, professionals confirmed concerns relating to the promptness of people's physical health. The lack of action could have put the person at risk of harm.
- During the inspection it was evident that there were diverse group of people with different support needs and interests were very different. When speaking with people they all said they got on well with each other, however, we observed some interactions that questioned the compatibility of the people living there. For example, people and staff said that they would spend time in their room so as not be around people and staff that made them uncomfortable.

People's care and support was not designed in a way in which met their health and wellbeing needs. People were not able to have choice and control about the services they received. This was a breach in regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff support: induction, training, skills and experience

- People were not supported by staff who had received the necessary training to support them. Staff told us and records confirmed that there were a number of staff who had not completed the mandatory training. For example, 18% of staff completed safeguarding training as well as 18% of staff completing mental health

awareness training. The Registered Manager told us further e-learning training sessions had been booked to address this.
● The Registered Manager did not ensure that new staff had a comprehensive induction. Although new staff had 2 days of shadowing before commencing on shift, training records showed that new staff were in post for a number of weeks before commencing any form of mandatory training.
● We observed some staff interacting with people in a kind way, however there were times where we observed other staff members not engaging in conversations and dismissing peoples attempts of communication.
● Staff did not receive regular supervisions or appraisals to review their practice and offer support.

There were insufficient numbers of suitably qualified, competent, and skilled staff deployed. This put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Adapting service, design, decoration to meet people's needs
● During the inspection we identified a number of issues relating to the environment and repairs required. This included worn carpets on stairs, as well as repairs required to walls, several bathrooms needed repair, we found stained flooring in bathrooms, chipped paint and bathrooms were left unclean.
● Parts of the home required a deep clean. In parts of the building there were strong offensive odours. This meant that people were living in an unpleasant and undignified environment.
● Equipment was not always reliable or serviced promptly. People shared at times the stair lift was not in use because it was not working. We also found equipment such as a profiling bed had not been serviced since 2018, where this should be completed yearly.

The provider failed to maintain good standards of equipment and cleanliness of the premises. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 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 legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People had restrictions on their liberty, without being properly involved in decision that led to the restrictions. We found examples where there were 'blanket rules' that meant people's choice and control were limited. Where people smoked the staff held onto their cigarettes without a best interest decision. The

front door was locked with a key code and people were unable to leave freely. One person said, "It's a prison. Not allowed to go out, you can't go outside."

● We observed people asking for cigarettes, in one case one person became distressed, a staff member approached the person and said, "stop it". After five minutes the staff member then brought a cigarette for the person.

● Not all staff we spoke with were aware of the principles of the Mental Capacity Act and these principles were not consistently embedded in their practice. Staff described how they held a person's key to their bedroom, which meant the person had to ask for staff to open their door every time they wanted to go to their room. When speaking with staff about the rationale for this, the staff were unclear. This meant people were being restricted without a best interest decision.

● Professional feedback said "Staff appear to be a limited understanding of the Mental Capacity Act in practice….there is a risk that they will impose this on the person rather than considering if the person wants to accept the recommendation."

● The Registered Manager failed to ensure appropriate mental capacity assessments were in place to make particular decisions. This included best interest decisions to determine safe ways to support people. This meant people's liberty was being deprived without proper assessments or allowing the person to be fully informed of the decisions being made about them.

● We saw no evidence that the registered manager promoted the use of advocacy services, where people required this in order to assist people to express their thoughts and ideas and to ensure their best interests were represented.

● The manager in the service had applied for DoLS for 2 people in the service. However we found that 5 other people were deprived of their liberty throughout the home, due to the restrictions in place, and there had been no applications made for them.

The provider failed to demonstrate they had considered the "least restrictive" option when supporting people. In addition to this they failed to ensure they followed current legislation and guidance. This placed people at risk of harm. This was a breach of regulation 11 (Need for Consent) 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 said the food was good and had a balanced meal, each day there were two options for people.

● People had access to fruit during the day, however people said they were unable to have access to any other snacks, however in some cases had to wait till staff went out to buy their items because they were unable to leave the house to get it themselves.

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

- The Registered Manager had failed to provide support that promoted choice and control when people developed their support networks.
- The management team had promoted person-centred, open and empowering care and did not recognise the importance of respecting people. People gave examples where staff would be dismissive of what they wanted and, in some cases, would be abusive, or staff would withhold items. This was raised with the management team people and staff, however some people felt that this did not drive change and some staff continued to communicate in a way that was not respectful.
- Although we saw some good interaction with some staff, we also found that others were task focused and did not speak with people they supported.
- Staff give mixed views about the open culture, some staff gave examples where they felt listened to, however other staff felt the supportive relationships were not always formed. Staff gave examples where they felt discouraged to raise concerns, but also did not want to raise concerns because of a fear or repercussions if they did.
- Support for staff from the management team was inconsistent. Some staff felt supported and could approach management whereas other did not. One staff member said, "If I have a problem I will go to [manager]." Another staff member said, "There is no one to go to, you cannot go to the manager as they will not listen."
- The management team had started forming senior support worker meeting and was in the process of starting to include all staff in team meetings. The manager had sent out surveys to people to get some views, however these had not been captured into actions to drive change.
- The management team liaised with other professionals when required. When we spoke with professionals they felt the management were responsive to what they needed.

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; Continuous learning and improving care

- The Registered Manager failed to have oversight of the support people were receiving and to mitigate the risks identified. People and staff fed back the service was run by the care manager and they did not have regular contact with the Registered Manager. The care manager told us they felt they could contact the

Registered Manager when they needed, however there were gaps in the staff knowledge in relation to the regulatory responsibility. This meant people were put at risk of harm.

● The management team did not adequately distinguish between the roles and responsibilities of its own staff. It was heavily reliant upon the senior support worker to complete tasks that should have oversight from someone who had the right skills. For example, we found medicine audits were being carried out but failed to identify key actions and improvements required for people to receive medicines safely. This put people at risk.

● The Registered Manager failed to report and notify the correct authority and CQC when safeguardings and where notifiable incidents occurred. During the inspection CQC raised a number of safeguarding alerts relating to people's health and wellbeing. We found that not only were external agencies not notified, but there were also no clear lessons learnt or actions developed from this incident to drive change and improvement to people's lives. This meant there was a risk of incidents reoccurring. The lack of reporting increased the risk of a closed culture developing in the service.

● The Registered Manager failed to ensure staff had completed mandatory training courses for their role. This training could improve staff understanding and adapt their way of working to improve the overall culture of the service.

● The Registered Manager lacked oversight of certain aspects of the care and care records being completed for people using the service. Care plans and risk assessments did not triangulate.

● The Registered Manager did not have a robust quality assurance system in place. Where audits and actions were completed, the management team did not have clear oversight that these were actioned. In addition to this the management team failed to identify some significant improvements needed in relation to health and safety, medicines management to keep people safe and the lack of clarity in the care plan and risk assessment documents.

● The Registered Manager did not analyse accidents and incidents and therefore, could not look at overall trends and themes, however had documented singular incidents. The manager had recently put in a log for incident and accidents, however not learning had been generated from this. During the inspection and feedback from staff they described there were a number of occasions relating to people becoming verbally aggressive towards staff and people. There was no consideration as to the support or training staff may need or if staff were adequately trained to deal with all situations that may occur.

● Our findings from the other key questions inspected showed that governance processes had not helped to keep people safe, protect their human rights and provide good quality care and support.

The culture of the service failed to support the provision of high-quality care and support. Quality monitoring systems were either not in place or robust enough to demonstrate the service 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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and support was designed in a way in which met their health and wellbeing needs. People were not able to have choice and control about the services they received. This was a breach in regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to demonstrate they had considered the "least restrictive" option when supporting people. In addition to this they failed to ensure they followed current legislation and guidance. This placed people at risk of harm. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 maintain good standards of equipment and cleanliness of the premises. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to have robust recruitment processes to ensure there were suitably qualified, competent and skilled staff where recruited. This put people at risk of harm. There were insufficient numbers of suitably qualified, competent, and skilled staff deployed. This put people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure they had robust systems to demonstrate safety was effectively managed, this included medicine management and risk management. This put 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.

The enforcement action we took:

Urgent Conditions imposed to the registration.

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 they had robust systems in place to protect people from abuse. This put people at risk. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment)

The enforcement action we took:

Urgent Conditions imposed to the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The culture of the service failed to support the provision of high-quality care and support. Quality monitoring systems were either not in place or robust enough to demonstrate the service 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:

Urgent Conditions imposed to the registration.