H U Investments Limited

St Martins

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Martins is 'care home' a providing personal care to up to 30 older people who may be living with dementia, in one large, adapted building. At the time of our inspection there were 25 people using the service.

People's experience of using this service and what we found
Relatives told us they felt their loved ones were safe living at the service, however, the quality of the service had deteriorated since our last inspection.

People had not been protected from abuse and discrimination. The registered manager had not reported incidents to the local safeguarding authority for investigation. There was a closed culture within the service, the registered manager and senior staff within the service were related. Staff told us they did not feel confident to raise concerns with the registered manager. The provider had not developed a strategy to manage the conflict of interest.

The culture within the service was not open and transparent, relatives told us they had not been informed when incidents involving their loved ones had happened. Staff told us, there was a toxic unprofessional culture and they had been reprimanded by management for acting to keep people safe.

Potential risks to people's health and welfare had been assessed but there was not always guidance in place to keep them safe, some guidance had placed people at risk. Fire risks had not always been assessed, fire drills had not been completed and people's evacuation plans were not up to date. Medicines were not always managed safely.

Staff had not been recruited safely, people had been placed at risk, by staff not having all the required checks before they started work. There was not always enough staff to meet people's needs, there had been a high turnover of permanent staff and agency staff were used to cover any gaps. Staff had not received inductions when they started at the service and their competency to undertake basic tasks had not been assessed.

People were not supported to have maximum choice and control of their lives and staff did not always 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 were not supported to make day to day decisions, the registered manager had placed restrictions on aspects of people's daily lives such as where they could eat their meals.

Records were not always accurate or did not exist, there were no records of pre-admission assessments being completed or referrals to health professionals made when people's needs changed. The service did not always follow government guidance, though visitors were welcomed into the service, they had not been

able to visit people in communal areas until 3 weeks before the inspection.

People were supported to eat and drink enough, but they were not offered a choice of meal at lunch time, there was limited choice of jacket potato or salad if they did not want the main meal. People were not always supported to eat their meal when it was served.

People, staff, and relatives had not been asked their opinion on the quality of the service or encouraged to make suggestions to improve the service. Checks and audits completed by the registered manager had not identified the shortfalls found at this inspection.

The providers oversight of the service had been poor until recently when the provider changed their representative to oversee the service. They had identified the majority of the shortfalls found at this inspection and had started to develop an action plan to improve the service.

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 21 November 2019).

Why we inspected
We received concerns in relation to the management of the service. 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Martins on our website at www.cqc.org.uk.

Enforcement and Recommendations

We have identified breaches in relation to safe care and treatment, recruitment, training, safeguarding people and 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.

Follow up

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

St Martins

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 undertaken by 2 inspectors.

Service and service type
St Martins 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 Martins 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. However, they were not working at the service at the time of the inspection and an acting manager was in place.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We 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 2 relatives about their experience of the care provided. We spoke with 3 people who were happy to speak to us about their experience of living at the service. We spoke with professionals who support the service. We observed staff interactions with people in the communal areas. We spoke with 10 members of staff including the nominated individual, operations manager, deputy manager, senior carer, care staff, cook and auxiliary staff.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 7 people's care plans and all the medication records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits, induction, and training matrix.

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.

Systems and processes to safeguard people from the risk of abuse

- There was not an effective system in place to protect people from discrimination and abuse. The registered manager had not identified incidents which met the threshold to be reported to the local safeguarding authority. This placed people at risk as concerns were not being investigated and action was not taken to reduce the risk to people.
- Staff told us they felt that there was a toxic unprofessional culture in part because some of the management team were related, so they didn't feel confident raising concerns. This was because concerns involving staff who were related had been raised previously, and action hadn't been taken. This placed people at risk of abuse and discrimination.

The provider and registered manager had failed to have effective systems and processes in place to effectively investigate allegations of abuse. This was a breach of regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection, the nominated individual told us, staff had been told they should report any concerns to the operations director or acting manager. Staff told us they felt more confident to report concerns now and that action would be taken.

Assessing risk, safety monitoring and management

- Potential risks to people's health and welfare had not been consistently assessed and there was not always guidance in place for staff to reduce the risks. Some people expressed distress and anxiety by displaying non-verbal communication including verbal or physical aggression. The strategies put in place did not always keep people safe. One person had used their walking stick to hit people. The walking stick had been removed from the person, when the occupational therapist had assessed the person needed a walking frame, this guidance was not followed. The person had been placed at risk as they were now mobilising without equipment. Triggers for the person's behaviour had not been identified and strategies had not been put in place to reduce the risk.
- Some people were living with diabetes. The care plans contained general information about the signs of high and low blood sugars, however, care plans did not contain person centred information. There was no guidance for staff about the normal range of the person's blood sugar. There was no guidance for staff about what action to take if the person became unwell. Some people had a catheter in place to drain urine from their bladder. There was general information for staff about caring for a catheter, however, there was no guidance about when to change the drainage bags and how to care for the catheter site.
- People were at risk in an emergency as their personal emergency evacuation plans did not contain enough information for staff or the emergency services to evacuate them safely. This included a lack of

guidance about how to evacuate people from the first floor who could not use the stairs. Staff had not been trained to use evacuation equipment or practiced evacuations. This left people at risk of serious harm.

The provider and registered manager had failed to assess the risks and doing all that is reasonably practicable to mitigate the risks. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Accidents and incidents had been recorded but had not been analysed to identify patterns and trends. In April 2023, a person had fallen 4 times, it had been recorded their care plan had been updated after the first fall. It was not clear what action had been taken to reduce the risk of falls and there had been no assessment or evaluation of the action after the other falls.

● When people had expressed their emotions with non-verbal behaviour this had been recorded. One person had 12 incidents recorded in April 2023 however, there had been no analysis of the incidents for patterns, and it was recorded that no further action was needed. People had been placed at risk as their needs had not been assessed and strategies not put in place to minimise the risk of the incident happening again.

The provider and registered manager had failed to all that is reasonably practicable to mitigate risks. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People were not protected by safe recruitment practices. Robust checks had not been completed on staff's character, skills and experience before they began to care for people. Gaps in staff employment history had not been consistently explored. Checks had not been completed on a staff members conduct in previous social care roles.

● Staff had work unsupervised with people before the outcome of their Disclosure and Barring Service (DBS) check had been received. For example, a staff member worked for approximately 4 months unsupervised before their DBS was received. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. This left people at risk of harm.

● There had been a 2 month delay in a risk assessment being completed for a staff member who had a disclosure on their DBS. This had been identified by the senior management team and action was taken shortly before our inspection to assess and mitigate any risks to people.

The provider and registered manager had failed to ensure staff were of good character,
and had the competence, skills and experience to fulfil their role. This placed people at risk of harm. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Sufficient numbers of staff had not consistently been deployed to meet people's needs. On the day of our inspection one health care assistant role was not covered. Other staff were not undertaking their substantive roles. Vacant shifts not being covered had been a regular occurrence. A senior manager had analysed staff deployment between 24 April and 21 May 2023 and found staffing fell below the required level for half of this time.

● A person told us they had waited a long time for their call bell to be answered on the morning of our inspection. They told us more staff were required at night. On the night before our inspection there were

only 2 staff on duty and not 3 as assessed to meet people's needs. Night staff had not been able to complete their tasks, and day staff covered them. This meant people's care and breakfast were delayed. We observed people had very little interaction with staff other than when they received direct care. One person was not supported to eat their breakfast for over an hour, while others waited a long time for their breakfast to be served.

● Staffing had not been planned around people's needs. For example, no senior carers had been deployed by the registered manager to work on a Monday as staff had said they did not want to work on a Monday. We would expect staff deployment to reflect the needs of people and the service at all times.

The provider and registered manager had failed to deploy sufficient numbers of suitably competent and experienced staff to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always managed safely and records were not always accurate. The service used an electronic system to order and record the administration of medicine. The records of the number of tablets available did not always match the number of tablets in the box, there were less tablets in the box. The number of tablets in the boxes were correct and people had received their medicines as prescribed.

● Some people were prescribed medicines to thin their blood placing them at risk of bruising and increased bleeding if they were to fall and hit their head or cut themselves. There was no risk assessment to provide staff with guidance about the action they should take if people had a fall or if they experienced excessive bruising.

● When people were prescribed medicines on a 'when required' basis there were no protocols about when to give the medicines, how often and when to review the medicine. One person was prescribed Paracetamol up to 4 times a day when required, they were having the maximum dose each day, staff had not requested a review of the prescription from GP.

The provider and registered manager had failed to manage medicines safely. This was a breach of regulation 12(2) 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 supporting people living at the service to minimise the spread of infection.

● 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 responding effectively to risks and signs of infection.

● 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

The service was open to visitors, however, the service had not consistently followed government guidance. Visiting risk assessments in people's care plans contained out of date guidance. Relatives confirmed they had been stopped from visiting people in the communal lounge until a couple of weeks before the inspection. Before the change, they had been escorted to the person's room and had to let staff know when

they were leaving to be escorted out of the building.

Requires Improvement

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 requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had not been consistently assessed to make sure staff could meet their needs. Before people moved into the service the provider's policy required a pre-admission assessment to be completed. There was no record of an assessment being completed before the most recent admission to the service. Since their admission, staff had not always been able to meet their needs, placing the person at risk of not receiving appropriate care.
- People's needs had not been consistently assessed using recognised tools such Waterlow score to assess skin integrity or nutritional assessments. Some people's care plans did not include any assessments using the tools, placing people at risk from weight loss and skin damage.

The provider and registered manager had failed to assess risks to people and doing all that is reasonably practicable to mitigate risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People were not cared for by staff who had the skills to meet their needs. Some new staff had not completed an induction when they began working at the service. A staff member told us, "I didn't really get an induction. Maybe shadowed for a day." Staff had learnt about people and what was required in their role from colleagues. Their ability to undertake basic tasks had not been assessed.
- A staff member who had not worked in care before had begun to complete the care certificate. This is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. They had completed written work but this had not been assessed and the provider and registered manager could not be assured they had the skills to care for people safely.
- Some competency assessments had been completed. However, where shortfalls in staff's practice had been identified, action had not been taken to support staff develop their skills.
- Staff had not met regularly with a member of the management team to discuss their practice and development needs. Gaps in staff's knowledge and skills had not been identified and staff had not been supported to develop in their role.

The provider and registered manager had failed to provide staff with appropriate support, training, supervision and appraisal necessary to carry out their duties. This was a breach of regulation 18(1) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

● Staff had applied for DoLS when needed, however, they had not identified to the local authority when applications were urgent. One person was continually trying to leave the service, when it was unsafe for them to do so, a DoLS application had been made but staff had not identified it as urgent.
● People had not been supported to make choices and decisions in their day to day life. For example, people had not been able to choose where they ate their meals, people had to eat their meals at the dining tables. Some people who had capacity to make their own decisions had been overruled by the registered manager. Some people had dietary requirements or food intolerances, they had managed all their lives, the registered manager had stopped them from eating certain foods they had previously eaten with no ill effects.

The provider and registered manager had failed to ensure care was provided with the consent of people. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, people were eating their meals where they wanted. Staff told us this had changed recently once the acting manager and operations director were spending time at the service.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not supported to eat their meal when it was served. Breakfast was late on occasions as people were waiting for assistance to get up, washed and dressed and there was a short gap between breakfast and lunch. There were risks people would not as eat much as they would normally because they were still full from breakfast. There was also a risk that people would be hungry because of a long gap between their evening meal and breakfast.
● Menus were planned in a 2 week cycle and people were not offered a choice of meal at lunch time. A jacket potato or salad were the only alternatives offered if people did not want the main meal. We would expect people to be offered at least two different choices at meal times each day, so they could make a choice about what they ate and offered a wide variety of foods.
● Menus were not displayed and we observed people were not told what they were being served at lunchtime. There was a risk people may not know what the meal was, so they could decide if they wanted something else.
● People's food intolerances were known and meals were prepared to meet their needs. Low sugar

alternatives were offered to people with diabetes. No one required the texture of their food to be modified to help them to eat and drink more easily.

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

● People had not been consistently referred to health professionals when their needs changed, and records of their visits were poor. There were no records that referrals had been made to health professionals such as dieticians. One person had nutritional shakes prescribed but staff told us these had been prescribed in hospital.

● People were referred to the GP and district nurse when required. People had been referred to the occupational therapist to assess their moving and handling needs. People told us they attended appointments with their family or staff.

Adapting service, design, decoration to meet people's needs

● The building had been adapted to meet most people's physical needs. However, further work was required to support people living with dementia to find their way around the building without support.

● One person told us they found it difficult to use the sink in their bedroom as there were no grab handles for them to hold on to while they stood and used the sink. They told us they felt unsafe when holding on to a wet sink or taps.

● The provider had redecorated some areas of the building and plans were in place to redecorate other areas. They had considered best practice and installed clear room numbers and memory boxes. However, the management team have not supported people and their families to fill the memory boxes to help people identify their bedroom.

● Some people had their name on their bedroom door, however, most did not. Again, action had not been taken to support people to identify their bedroom with a clearly written sign and a picture the person would identify as personal to them. Clear signage had been used on some doors but not on others to support people to find bathrooms, toilets and other areas easily.

● The garden was secure and accessible to people. There were areas of shade for people to sit in and suitable tables and chairs for them to use. People were growing some flowers and supported staff to keep them watered.

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

- The registered manager and provider had not developed a positive, open culture at the service. Six of the registered manager's relatives and close friends worked there. Strategies had not been put in place to manage any conflict of interests. Staff were not confident to challenge practices as they felt they would not be listened to by the registered manager and action would not be taken to address the concerns. A staff member told us, "I can't go to anyone to raise concerns."
- Staff described a toxic unprofessional culture where staff were not treated equally and there was a divide in the staff team. Staff told us, "Some staff do whatever they want" and, "There is so much stirring. There is no structure, staff tell tales and the managers stomp around. The registered manager and their family all stick together." We observed some of this behaviour during our inspection. A staff member described a member of the management team as being 'A bit harsh' and described 2 occasions when they had been reprimanded for trying to keep people safe.
- Staff told us they had not felt supported or motivated by the management team. A staff member told us, "I hated the job until a few weeks ago.". They described how they were 'uncomfortable' supporting some people when they were anxious or worried and had not been trained how to support people with their emotions.
- The provider had identified the culture at the service needed to change. They had deployed an acting manager who staff told us treated people and staff fairly. Staff told us they were "kind," treated the service like people's home and were "Open to issues and invites feedback". Restrictions on where people could eat had been removed and some staff's hours had reduced at their request when they felt very tired.

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; Working in partnership with others

- The registered manager had not always been open and honest when things had gone wrong. They had not always informed the local safeguarding authority when incidents had happened which met the threshold for investigation.
- Relatives told us they had not been informed when their loved ones had fallen, they had found out from other professionals or when they visited. One relative told us they had not seen the registered or deputy manager, but the acting manager had introduced themselves and were happy to discuss any concerns they had.

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

regulatory requirements; Continuous learning and improving care

● Effective systems to monitor the quality of the service were not in place. The provider had not had effective oversight of the service until recently, the previous nominated individual had not identified shortfalls within the service. When the current nominated individual took up their role in March 2023, they commissioned a mock inspection audit. This audit identified significant shortfalls within the service. The registered manager was given an action plan to complete urgently, in May 2023, the registered manager had not completed the action plan and further shortfalls had been identified.

● Checks and audits had been completed by the deputy manager and signed off by the registered manager, these audits had not identified the shortfalls found at this inspection. The deputy manager had completed audits on areas of the service they oversaw, for example, they had written, reviewed and audited the care plans. The audits had not identified shortfalls with training, recruitment, medicines, and safeguarding found at this inspection. During the inspection, we asked to look at one staff member's record in relation to induction, training and supervision and were told by the deputy manager it had, 'disappeared'. The operations director told us previous staff rotas were not accurate and did not reflect who had worked on each shift.

● The registered manager had not kept up to date with current guidance such as visiting guidance.

● The acting manager and operations director had developed an action plan and prioritised areas that needed improvement quickly, such as risk management, safeguarding and consent.

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

● People, staff, and relatives had not been consistently asked for feedback on the service. There was no record of staff or relative meetings having taken place. People had been asked by the activities co-ordinator about the menus and what activities they wanted but this had not been recorded formally or implemented. Quality assurance surveys had not been sent to people, relatives or staff to ask about the quality of the service.

The provider and registered manager had not operated effective systems to assess, monitor and improve the quality and safety of the service, assess, and monitor the risks relating to the health and safety of people and maintain accurate and complete records. This was a breach of regulation 17(1) 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 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager had failed to ensure care was provided with the consent of people. Regulation 11 Need for consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager had failed to have effective systems and processes in place to effectively investigate allegations of abuse. Regulation 13(3) Safeguarding 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 provider and registered manager had failed to ensure staff were of good character, and had the competence, skills and experience to fulfil their role. Regulation 19(1) Fit and proper persons employed

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider and registered manager had failed to deploy sufficient numbers of suitably competent and experienced staff to meet people's needs.

Regulation 18(1) Staffing

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 and registered manager had failed to assess the risks and doing all that is reasonably practicable to mitigate the risks. The provider and registered manager had failed to manage medicines safely. Regulation 12(1) Safe Care and Treatment

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had not operated effective systems to assess, monitor and improve the quality and safety of the service, assess, and monitor the risks relating to the health and safety of people and maintain accurate and complete records. Regulation 17(1) Good Governance

The enforcement action we took:

We imposed a condition on the provider's registration