Michael Batt Charitable Trust

Rushymead Residential Care Home

Inspection report

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22 November 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rushymead Residential Care Home is a residential care home providing personal care to up to 28 people. The service provides support to older people some of whom are living with dementia. At the time of our inspection there were 22 people living at the service.

The care home is located in a large three storey building. The building is located in extensive grounds in a rural part of Buckinghamshire. People's bedrooms were located on each floor, each floor had a small lounge and kitchenette area. People had access to two large ground floor rooms where group activities could take place.

People's experience of using this service and what we found
People were not routinely protected from risk of injury or avoidable harm. Risks associated with fire were not always identified by the registered people or acted upon when they were made aware. Fire risks identified by the provider's own fire risk assessment in March 2023 and by Buckinghamshire Fire and Rescue Service had not been actioned by the provider in a timely manner.

People were left at risk of potential abuse. Staff did not always recognise when abuse had occurred. For instance, people had been physically assaulted, intimidated and had other residents enter their room without permission. These had not always been referred to the safeguarding authority or investigated by the registered manager or provider to prevent a reoccurrence.

People were put at risk by poor recruitment processes and systems. The registered manager and provider did not ensure all the required pre-employment checks were completed before staff worked with people.

People were at risk of infections due to poor hygiene and a lack of preventative measures to stop or prevent the spread of infections.

People were put at risk of harm as the registered manager and provider failed to ensure all accidents and incidents were recorded, investigated, and analysed to identify trends.

The service was not well led. Both the registered manager and provider failed to ensure they maintained compliance with the regulations. We did not always receive the required legal notifications of certain events, like safeguarding and serious injury.

We found the care records within the home to be disorganised, unclear, not complete or accurate. For instance, some records showed a lack of hydration and personal care offered to people. We found confidential records relating to staff and the home management were easily accessible to unauthorised people.

We have made a recommendation about ensuring guidance for staff on how to give liquid medicines support other risk assessments. For instance, when people require thickened fluids, we found some medicine records contradicted other risk assessments for how medicine should be given and how they should be thickened.

We have made a recommendation about ensuring people are referred to external healthcare professionals in a timely manner to prevent a deterioration in their health.

People told us staff were kind and responded to them when they pressed the call bell. Relatives gave us mixed feedback. Comments included "They really do a wonderful job there," "Staff know us and always acknowledge our visit," "All the staff we have seen seem happy in their work," "They are certainly always busy" and "The carers are all very nice."

Negative comments from relatives included "I feel it would be better for residents if all carers wore name badges. Especially as some of the weekend staff wear a different uniform," "There did seem to be activities at first, but they have definitely dropped off now," "I don't think that Rushymead is a dementia care home from what I can see," "The home haven't really been keeping me posted about what is happening with mum, but then they have a high turnover of staff" and "Sometimes we find him unshaved and his hair has got a bit long."

People were not always supported to have maximum choice and control of their lives, however, staff supported them in the least restrictive way possible and in their best interests. We found improvements were required in the policies and systems at the service to ensure when people's movements were restricted, legal authorisations were in place.

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 4 April 2018)

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We received concerns in relation to good governance and safeguarding people. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

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

Enforcement and Recommendations

We have identified breaches in relation to risk management, safeguarding people from abuse, safe recruitment and staffing. We have also identified concerns about infection prevention and control, leadership and governance. The registered manager and provider were unable to demonstrate an understanding of their legal responsibilities to notify the Care Quality Commission of certain events.

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

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 the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Rushymead Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this focused 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 two inspectors, a regulatory co-ordinator joined the inspectors on day two. An Expert by Experience made telephone calls to people and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care.

Service and service type
Rushymead Residential Care Home 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. Rushymead Residential Care Home 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 absent from the home. The home was being supported by an interim manager and existing senior staff.

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 and consider evidence we found on a direct monitoring activity. We sought feedback from the local authority. 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 the interim manager, care team supervisor, general assistant, 2 team leaders and 5 care staff. We reviewed a range of records. This included 6 care plan records and 2 medicine recording charts. We looked at safeguarding records, training, complaints and 3 staff recruitment files. A variety of records relating to the management of the service, including policies and procedures were requested from the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We sought feedback from staff and community professionals by email.

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

- People were not kept safe from avoidable harm because staff did not always know them well or understood how to protect them from abuse. The service did not work well with other agencies to protect people from abuse.
- One person told us they did not feel safe at night, as another person entered their room at night. We noted this had been recorded in records from April 2023. The person had spoken with the registered manager about this. However, no safeguarding referral had been made. On 22 November 2023 we discussed this with the interim manager who stated they were aware of the situation. However, no safeguarding referral had been raised.
- We found a record dated 24 October 2023 which referred to physical assault on a person by another resident. Another record dated 16 October 2023 referred to a person acting in an aggressive manner towards another person. No safeguarding referrals had been made for these events, or action taken to prevent a re-occurrence.
- We found evidence of unexplained bruising and broken bones, which had not been reported to the local authority for investigation.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment,) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People were not routinely and consistently protected from potential risks. The provider had failed to identify, assess and do what was reasonably practicable to mitigate risks to people.
- People were not routinely protected from the risk of fire. Fire risks identified by provider's own fire risk assessment dated March 2023 and in Buckinghamshire Fire and Rescue (BFRS) letter of fire safety dated 3 November 2023 had not been actioned by the provider. Verbal feedback had been given to the senior staff at the time of BFRS visit on 28 September 2023. We sought reassurance from the provider, however there was a delay in their response.
- Staff were ill-equipped to support people in the event of a fire. Fire drills had not been completed in the last year, no fire simulation activity has been completed. Staff feedback confirmed drills and simulations have not occurred. This was highlighted to the provider on 28 September 2023 by BFRS. We sought reassurance from the provider fire drills would be carried out. The first fire drill happened on 28 November 2023. This meant there was an unnecessary delay in protecting people from the risk of fire.
- People who were assessed at high risk of falls, were not always supported by staff to ensure they were safe. One person had a risk assessment dated 28 July 2023 which stated, "Staff should be aware of where I am at all times and ensure I have a call bell to hand in case I need to alert staff to assist me to walk

somewhere, i.e. toilet." However, we observed the person was left up to and in excess of 20 minutes in the lounge with no staff present. Inspectors had to seek staff support to prevent the person from falling whilst attempting to rise from the chair unaided.

● Risks associated with pressure damage were not routinely managed. For instance, one person's pressure area care assessment stated the necessity to monitor food and fluid intake, as a control measure. Fluid charts showed poor recording, or the person was not offered sufficient drinks. For instance, records showed on 19 November 2023 the person had received 250 ml of fluid and on 20 November 2023 they had received 350 ml of fluid. This had the potential to put the person at risk of dehydration and a deterioration in their skin integrity.

● People were at risk of injury whilst being supported to move position by staff. We observed staff did not routinely ensure people had their feet on foot plates whilst using wheelchairs. There are industry known risks of injury when this occurs. On 22 November 2023 we observed 1 person being supported by staff, they were clearly in discomfort as their feet were not being supported by foot plates. Incident forms showed people had suffered injuries whilst being supported by staff to move position.

● Staff received training on how to support people move positions from senior staff who had not kept their own skills and knowledge updated. Records showed the member of staff who acted as the training instructor for staff conducted the train the trainer course in 2011. We noted they had last completed their own moving and handling training in 2014. The provider's own records showed this should be updated each year. This had the potential to put people at risk of harm and injury due to the training being out of date.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. We found improvements were needed to ensure applications were made when an authorisation had expired.

Preventing and controlling infection

● People were not routinely protected from the risk and spread of infection.

● We found poor infection control measures were in place, for instance, staff wearing nail varnish. On 16 November 2023 we discussed this with the interim manager. However, on 22 November 2023 we again observed 4 staff wearing nail coverings. We were concerned with the lack of action taken when this was first highlighted to the interim manager.

● We observed and we received feedback about the lack of clean and hygienic surfaces. For instance, we observed dirty kitchen areas and equipment which had not been cleaned.

● We found there was a high risk of cross infection in the laundry and people's living areas. We found personal belongings and drinking mugs in the laundry. We found staff personal bags and coats were left on dining room chairs.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People were not routinely supported by staff who had been through safe recruitment processes. Recruitment records viewed showed the service had not carried out all the required pre-employment checks for new staff. This included an employment history, references and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. We found DBS checks were not routinely carried out prior to a member of staff working with people.

● One member of staff had commenced work on 23 March 2023 however, the service did not receive a DBS record until 24 May 2023. This meant the member of staff could have posed a risk to people.

● Staff who have criminal convictions should be open with providers about their criminal history and providers should ensure a robust risk assessment is carried out to ensure the member of staff is suitable and does not pose a risk to working with people. We found the provider failed to ensure risk assessments were in place. This meant the registered manager and provider failed to protect people from unsuitable staff.

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 home used agency staff. We noted staffing rotas showed it was usual for a third of the staff working on any shift were agency staff. Prior to agency staff working at the home, providers should ensure they had checked the suitability and training of agency staff. However, on 16 November 2023, we were made aware 2 agency staff worked in the care home. We asked what checks had been carried out on the 2 agency staff working on 16 November 2023. The interim managers confirmed no senior staff had checked their suitability or reviewed their agency profile. The 2 staff who worked on 16 November 2023, had not received an induction prior to them working with people. On the 23 November 2023 the interim manager confirmed there was no formal written process to ensure agency staff had a robust induction.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● We found systems were either not in place or effective to ensure learning from events was embedded into the improvement of safety for people who were supported. This placed people at risk of harm.

● People who had fallen or had suffered injuries were not protected from a future re-occurrence. The provider's policies and procedure were not robust enough to ensure all accidents, near misses were recorded and investigated.

● We found accident forms were not always completed for falls, aggressive behaviour or unwanted access to people's bedrooms.

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 received support with their medicine by staff who had received training.

● We observed people were supported with their medicines in a calm and dignified manner.

● Staff had access to guidance on side effects of high risk medicines, such as blood thinning medicine. However, we noted some of the guidance did not always reflect other records relating to people's risk. For

instance, one person required liquid medicine to be thickened. We noted the record did not match the fluid guidance in their care plan.

We recommend risks associated with medicines clearly support other care plans in place.

Visiting in care homes

- People were able to receive visitors without restrictions in line with best practice guidance.
- There were no restrictions on visiting times in the service. Family members could always visit. Some family members were able to freely access the building as they had the key code. This could put people at risk if they were to allow entry by an unknown person. We have discussed this with the interim manager to consider what action is necessary.

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

● People were not routinely and consistently protected from risks and avoidable harm. This was because the registered manager and provider did not have effective systems in place to monitor, manage and improve risks.

● People, relatives, and staff told us there was a lack of communication with them about any changes which had occurred at the home. Staff felt let down by the provider and did not feel they could approach the provider in the absence of the registered manager.

● We found audits carried out did not have the desired effect to drive improvement in the service. A quality assurance and management policy dated 25 March 2023, identified a number of audits which should have been completed, however, when we asked to see completed audits, we were only sent a few. The interim manager confirmed "I confirm that I have sent you all that was available to me."

● The provider is a charitable trust. We found little or no evidence of visits to the home by the board of trustees. The Trust met with the registered manager virtually. Minutes of meetings held appeared to be heavily occupied by discussing home occupancy and finance, rather than quality of care and support provided to people.

● The practices we observed did not routinely demonstrate a person centred culture. We observed mealtimes both on 16 and 22 November 2023. We found people were not routinely offered to sit at a table. We observed people had to lean forward to eat, the seating and the height of the table did not promote a good posture for eating. On both days of the inspection, we observed televisions remaining on and set at a high volume during lunch.

● We observed some people were unshaven and hair not brushed. We received feedback from 1 relative who confirmed they were concerned about their family member. Another relative told us they had taken bedding into the home for their family member to use as the home's supply was of a poor quality. Records showed people were not routinely offered a bath or shower.

● On 16 November 2023 and 22 November 2023, we observed people were left in the same chair for hours at a time. We observed very little support being offered to people with personal hygiene or toileting. This was supported by feedback we received. One comment stated, "Residents are often not being toileted during the day and most of the times left with the same pad on since they woke up 'till the evening" another comment we received was "Residents don't have a shower or a bath for months and months, just a quick 'wash'". Records supported the comments made. One person's records showed they had received infrequent support with bathing in 2023. For instance, records showed they had been supported on 3 August 2023 and the following record was dated 27 September 2023. We noted records referred to people supported with

washing and staff referred to using "dry wipes".

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed permanent staff showed kindness towards people. People told us they thought staff were caring and approachable and responded to them when they called for assistance.
● Relatives told us they were happy with the home, comments included "They [staff] will bend over backwards to do whatever is asked of them and the regular staff seem very knowledgeable. They certainly have infinite patience", "Most of the carers make a difficult job look relatively easy" and "I think it takes a caring person to do this job. Some [carers] just have an easier way with residents than others, but certainly no manhandling or raised voices."
Continuous learning and improving care
● We found all accidents, near misses and incidents were not routinely recorded, or reported to the management team. Staff informed us when they had previously raised concerns to the registered manager, they were not always acted upon or taken seriously.
● The provider had received feedback from the local authority and the Buckinghamshire Fire and Rescue Service. However, little or no action had been taken to improve the safety and experience of people when we visited on 16 November 2023.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● People were supported by a service which was not safe. There was a clear lack of registered manager and provider oversight and governance at the home. None of the concerns identified by us had been identified by the registered manager or provider.
● We found records were not contemporaneous and accurate. Fluid charts were not routinely completed satisfactorily or monitored. For instance, 1 person's records stated they had received 160ml of fluid on 9 November 2023, on the 26 November 2023 their record showed they had received 800ml of liquid. We checked other records available to identify if staff had acknowledged low fluid intake. We found handover records did not provide any reassurance on when action was required to increase a person's fluid intake. We checked with the interim manager if any other records existed and they confirmed we had seen all that was available.
● We found there was a failure to follow the provider's own policies and procedures. For instance, a safeguarding policy dated 14 September 2023 stated "The care home therefore works on the basis that it will treat any sign of emotional distress (as well as of physical harm) on the part of a vulnerable person that appears to be caused by their social contacts and relationships as possible abuse that will need to be reported, followed up, inquired into and if necessary fully investigated in line with the care home's general safeguarding policy and procedures." We found this not to be the case and safeguarding referrals were not routinely made to the local authority.
● We found there were unnecessary delays at provider level to actions concerns shared with them. We found the inspection processes unnecessarily delayed due to the lack of available information.
● We found the provider, or their representatives did not always respond to requests for information or clarity from us. We have discussed this with the provider's representative to ensure requests for information were responded to in a timely manner.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and provider had not ensured all events which were legally required to be notified to us where made. An example is when a person has sustained a serious injury, or a safeguarding concern had been raised with the local authority. On 16 October 2023 a care home pharmacist carried out an audit on medicine practices at the home. They identified concerns around a person's Parkinson medication. The pharmacist asked the service to raise a safeguarding referral which they did. However, the service did not make a statutory notification to us.
● One relative told us their family member had fallen at the home and had "snapped their hip". We received no notification about this.
● We found evidence of safeguarding concerns which should have been reported to the local authority and notified to us. We had previously spoken with the registered manager about this. We found there was a lack of action in the past by the registered manager. There was a lack of oversight from the provider, and no consistency or system in place to ensure statutory notifications were made.

This was a breach of Regulation 18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009

● Providers are required to notify us when any changes of nominated individual. The Nominated individual (NI) is responsible for supervising the management of the service on behalf of the provider. On 2nd October 2023, the CQC were made aware the provider had agreed a change in the NI. Advice was provided to the incoming NI on how to ensure the CQC received a correct notification. This included provided the form to be completed and the email address where it needed to be sent. The CQC received the completed forms on 16 November 2023. This was an unnecessary delay.
● Providers are required to notify us when a registered manager is absent from the service and who is managing the service in their absence. On 2nd October 2023 CQC were made aware the registered manager was absent from the service. Advice was given to the provider on how to legally inform the CQC of this. The CQC did not receive the statutory notification until 13 November 2023.

This was a breach of Regulation 15 (Notice of changes) of the Care Quality Commission (Registration) Regulations 2009

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People and staff were asked to complete questionnaires about their experience, however, we found the registered manager had not responded to the feedback. There was no analysis to drive improvement.
● We found mixed evidence about timely referrals made to external healthcare professionals. We noted a lack of safeguarding referrals being made. However, referrals to the community nursing team were made when required.
● One person had been identified as in need of a wheelchair. A referral form was completed on 15 November 2023 however, it was not sent until 27 November 2023.

We recommend the provider seeks advice from a reputable source on how and when to make timely referrals to external parties.

● A senior member of staff represented the care home at local are homes and community engagement project. This was an opportunity for local care homes to share learning and look at activities people could

partake in.

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

● Providers are required to comply with the duty of candour (DOC) statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

● We found senior staff had undertaken appropriate steps to ensure people were offered and had a written apology.

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 15 Registration Regulations 2009 Notifications – notices of change How the regulation was not being met We were not always notified when changes occurred in the management of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met We were not always notified of certain events, like safeguarding concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met People were not routinely supported by staff who had been recruited safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met People were exposed to risk because there was a failure to implement robust induction and checks for agency staff.

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 How the regulation was not being met People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance, risk assessment and management. Risks posed to people's health was not routinely management effectively.

The enforcement action we took:

We issued a notice to cancel the provider's 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 How the regulation was not being met People were not always protected from abuse and improper treatment.

The enforcement action we took:

We issued a notice to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met Governance systems were ineffective in monitoring and improving the service people received. Records lacked detail, accuracy and were not always stored securely.

The enforcement action we took:

We issued a notice to cancel the provider's registration.