Care Quality Commission

Chilton House Limited

Chilton House

Inspection report

Chilton
Aylesbury
Buckinghamshire
HP18 9LR
Tel: 01844 265200
Website: www.chiltonhouse.co.uk

Date of inspection visit: 7 & 24 September 2015
Date of publication: 26/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on 7 and 24 September 2015. Chilton House is a nursing and care home that provides support for people who are elderly and physically frail. The home can provide care for up to 45 people in both shared and single bedroom accommodation. There was no registered manager in place on the day of the inspection, however, a new manager had commenced employment between the first and second day of the inspection.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living in the home, however we found that documents such as risk assessments, treatment plans and care plans were not always completed. This placed people at risk if the care they required was not clearly documented. Recruitment

Summary of findings

checks on staff were not always recorded. This meant when new staff were employed there was not always records to show the provider had taken the necessary actions to ensure they were safe to work in the home.

A trip hazard such as the steps leading into some people's rooms had not been identified or highlighted for people. This placed people at risk of falls. We have made a recommendation about keeping the environment safe.

Staff were aware of how to protect people from abuse and knew how to respond to concerns. They were confident they would raise concerns regarding poor practice if they were aware of any. They told us the provider was approachable and there was an open and honest culture in the home, where staff supported each other.

Most staff and people told us there were sufficient numbers of staff to support people with their care. We observed adequate numbers of staff during our inspection.

People were supported to take their medicines safely by trained nurses. People told us they thought staff were knowledgeable and skilled. Training records were not up to date and certificates related to staff training were not all available. Staff supervision records showed staff did not receive supervision and appraisal in line with the provider's policy. Systems were not in place to ensure staff were supported to carry out their role.

Most people living in the home were able to make choices and decisions for themselves. For people who were unable to do so the Mental Capacity Act 2005 and the code of practice guide staff on the appropriate actions to take including assessing a person's mental capacity. Staff were not always clear about what the Act meant in regards to their role. One mental capacity assessment had not been completed correctly. We have made a recommendation about staff training on the subject of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

People were supported with their food and drink and commented that the standard of food was that of a high class restaurant. Where people needed extra support or help, for example by a speech and language therapist this was provided. People's health and social needs were met by staff who were caring. Health appointments were made to ensure people remained as well as possible. A wide range of activities was available to people including outings and in house entertainment.

We observed staff treating people with dignity and respect. They showed sensitivity when required and people appeared comfortable around them, laughing and joking and having meaningful conversations. The home had a relaxed atmosphere; it was clean and pleasantly decorated. People were encouraged to personalise their own rooms with their own furniture and belongings.

The lack of managerial support meant there had been no oversight of some aspects of the home, for example record keeping. People spoke positively about the provider and the care they received. Checks were carried out to ensure the health and safety of the environment was of a safe standard.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People told us they felt safe living in the home.

People were placed at risk of harm as the planning of care and the associated risks had not been documented.

Checks taken to ensure staff were safe to employ were not always evident

Is the service effective?

Requires improvement

The service was not effective.

Records did not demonstrate staff had received appropriate and up to date training or support to carry out their roles. They did not receive regular supervision and appraisals in line with the provider's policy.

Not all staff understood how the Mental Capacity Act and the Deprivation of Liberty Safeguards applied to their role and the people they were caring for.

Is the service caring?

Good

The service was caring.

People told us the staff were very caring, supportive and helpful.

We observed staff caring for people in a humane and sensitive way.

People told us they were involved in the planning of their care and how it was carried out. Staff respected their choices and treated them with respect.

Is the service responsive?

Good

The service was responsive.

Staff knew the people they were caring for, their preferences and needs.

People enjoyed a wide range of activities and were able to pursue hobbies and interests.

People knew how to complain, and complaints were dealt with in a timely way.

Is the service well-led?

Requires improvement

The service was not well led.

There was no registered manager in place.

The monitoring of records had not been completed and had resulted in weak guidance for staff on the care being provided.

Staff were clear about their roles and responsibilities and who they were accountable to.

Chilton House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 24 September 2015 and was unannounced.

The inspection team was made up of a specialist nurse advisor, a lead inspector and an expert by experience who had experience of care for older people and those who live with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed previous inspection reports and other information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

We spoke to eight people and one relatives and one visitor. We interviewed nine staff including the owner and used observations to see how care was provided to people.

We reviewed 12 care plans, medicines records and records related to the running of the home.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Chilton House. Comments included "I feel very safe here". A relative of someone living in the home told us "I like the staff, and I am not worried about anything and have no concerns at all, I am happy with the level of care X (family member) receives at Chilton House."

When we reviewed the documents related to how people should be cared for we found gaps in the information. For example, care plans did not always describe people's needs; one person who had a skin condition had no care plan in place to ensure their condition was monitored. One person had pressure sores. The nurse told us the wounds were improving and records confirmed this, but the information in the treatment plan was out of date. There were no risk assessments completed in relation to their pressure sores. Some people who stayed at the home for convalescence or respite care did not have risk assessments in relation to the care provided. Other people had risk assessments in place but no risk management plans or care plans to demonstrate how these risks could be minimised. This placed people at risk of harm as staff may not be aware of the needs of individuals or the risks associated with their care.

We discussed our concerns with the clinical lead nurse. They explained they were new in post and had identified the same concerns we found in the care planning and risk assessment documentation. They showed us the new care plans, risk assessments and associated documentation they were planning to introduce to improve the situation. When completed these would inform staff how to carry out care in a safe way. We found no indications that people had been harmed by the lack of documentation; however there was not the required guidance for staff to ensure all the needs of each person would be met.

This is a breach of regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment files for staff and found other documents were not in place. These included references for one staff member prior to being employed at the home and a copy of the disclosure and barring service (DBS) check carried out for another staff member. The checks were important to ensure staff were safe to work with people in the home. The home's practice was to review information supplied by and about applicants including application forms, adult first checks and references from previous employers. We discussed this with the provider, following the inspection they took action to ensure the necessary checks on the two staff members were followed up.

This is a breach of regulation 19 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health and safety audits had been completed to ensure the environment was safe. We repeatedly found a problem with the entrance to some people's rooms. This was because some rooms had a small step at the entrance. This caused the inspector to trip, as the leading edge of the steps was not highlighted. This posed a risk of falling to people with poor eye sight or mobility problems.

We recommend that the service seek advice and guidance from a reputable source, about how to ensure the environment is safe for people with disabilities.

Staff were aware of how to protect people from potential abuse. They were able to describe indicators of abuse and knew how to respond and who to report concerns to. In the staff office we saw the local authority safeguarding information was displayed to assist staff to know how to report safeguarding concerns when appropriate. Staff told us they would have no hesitation in reporting a safeguarding concern raising issues about poor standards of care.

People's safety had been considered as part of the equipment available to them both within and outside of the home. People had call bells in their rooms to alert staff if they needed assistance. One resident explained they had an alarm buzzer on a cord around their neck which was used for "ordinary" calls for assistance. However if they needed urgent assistance they had another large call button on their table which they said "would really stir them up (staff) and they come immediately if I press the big orange button". Several people told us the average response times when they used the call bells were approximately two to five minutes. One person told us they had experienced a fall and they were immediately surrounded by staff to help them and that the staff response to calls and incidents was "immediate." The two

Requires improvement

Is the service safe?

call bell systems worked through internal mobile phone units which staff carried around, this allowed staff to respond to the alarm and also communicate with each other if needed.

People and staff told us they thought there were sufficient staff numbers when there was a full complement of staff. Staffing levels were appropriate to the number of people who used the service. We saw there were adequate numbers of staff available on the day of the inspection to meet people's needs. We were told there was approximately 60 staff to meet the needs of 25 people who were residing in the home. The staff team was divided into groups covering nursing and care, hospitality, housekeeping, maintenance and administration. Where staffing levels fell short due to staff absence the provider stepped in to assist along with agency staff when required.

People were supported to take their medicines safely. Staff who were authorised to administer medicines had been trained and were registered nurses. The Medicine Administration Records (MAR) were up to date and the amount of medicines administered was clearly recorded.

The MAR charts and stocks we checked indicated that people were receiving their medicines as prescribed by healthcare professionals. Medicines prescribed for people using the service were stored securely and safely. Medicine audits were regularly carried out to ensure people received their medicines safely and to determine if staff required additional training to administer people's medicines safely by a visiting pharmacist. Protocols for the administration of 'as required' medicines were available. These protocols provide guidance as to when it is appropriate to administer an 'as required' medicine and ensure that people receive their medicines in a consistent manner. We were assured that all people within the home were having their 'as required' medicines offered to them when they needed them.

Infection control systems were in place to prevent the spread of infection. Cleaning staff were employed to ensure the home was kept clean and care and nursing staff wore protective clothing such as gloves when supporting people with personal care. Records showed 83% had completed infection control training.

Requires improvement

Is the service effective?

Our findings

People told us they thought the staff were skilled and knowledgeable in how to carry out their roles. One person told us they felt safe because "I have medicines every day that are dealt with by qualified nurses… carers are very good they are trained in how I like to take a shower." Other people stated "Staff regularly drop in to see me and bring hot drinks. They help me with showering and dressing in the morning. I do as much as possible and they do the rest. They are very helpful and supportive."

Staff received an induction when starting work in the home, this covered training in areas such as infection control, health and safety, diet and nutrition, moving and handling amongst others. During their first two weeks of employment new staff received support from more senior staff by shadowing them and observing how they provided care. Although some training records were available we were unable to see any records related to the completion of induction. Those we did see were from 2014 and had gaps in the records of what areas were covered. The training policy had inaccurate information within it for example it stated "New staff will register on CQC's mandatory care certificate training programme." Training certificates were not always available in staff files. On the second day of the inspection the new manager presented us with training and staff file action plan. This included how they would address the above concerns.

Most of the staff were not supported through regular formal supervision and yearly appraisal in line with the provider's policy. The provider's supervision policy stated staff should receive supervision six times a year as a minimum. This would take the form of a formal discussion lasting 10 to 15 minutes. Records showed this was not happening, this was corroborated by what staff told us. Staff told us when they did get supervision they found it useful. The provider told us they were aware of this concern and had recently appointed an assistant team leader to support the new manager. Their aim was to improve on the level of supervision and training staff received.

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

Other support was offered to staff through staff meetings and handover meetings. Staff told us the provider also offered them support and was approachable.

Most people living in the home had the ability and the mental capacity to make their own decisions about how they lived their lives and how they wished their care to be provided. One person's care plan stated they did not have this ability and their mental capacity had been assessed. However, we found that the assessment was not completed in line with the MCA code of practice. Where a person's capacity was in doubt a general mental capacity assessment had been completed, it was not time nor decision specific. This did not inform staff of the person's ability to make a specific decision or consent to their care. Staff were not clear about how the Mental Capacity Act and the deprivation of liberty safeguards (DoLS) applied to their role. When we spoke to clinical lead they were clear about how the act should have been applied and how a person's mental capacity should have been assessed. They had included this area in the list of things to be improved.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. No DoLS applications had been made, however in line with the re assessments of a person's mental capacity the provider told us they were considering making a DoLS application. We found staff to be acting in the person's best interest and restrictions placed on them were proportionate.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported with their hydration and nutritional needs. Records showed 76% of staff had attended training in nutrition and diet. Food was provided either in the dining room or in people's rooms. People were able to choose where they ate. One person told us "There is a good choice and a nice layout. I try to use the dining room. I get there about 90% of the time. I like to have breakfast in bed. I still regard that as a treat."

Where people required support with eating or drinking this was provided by staff. The chef was supplied with a list of people's preferences, likes, dislikes and food allergies. This enabled them to produce meals that were in keeping with what people needed and liked. People praised the food in the home, saying it was "very good and there is plenty of it." Three people told us after lunch they had enjoyed their lunches and that the service was very good. Menus were provided to enable people to choose what to eat. Where a

Is the service effective?

person did not want what was on the menu an alternative dish was provided. The menu for the week of the inspection showed people were offered each day a range of dishes for each meal including no meat or vegetarian options, a choice of potatoes, and fresh vegetables. Alternatives of pasta and other lighter options including salads were also available. Hot and cold desserts were served and fresh fruit was available both at meal times and any time during the day. Snacks were available in the evening along with drinks. Jugs of drinks were visible in people's rooms.

Documents showed where people had problems with chewing or swallowing a referral had been made to a speech and language therapist, (SALT) and the recommendations they had made had been followed through by staff. People were able to influence the types of food served in the home through discussions at the residents meetings. These had been recorded in the minutes of the meetings.

People were assisted to access the healthcare support they needed when they required it. The local GP visited the home regularly and on request. A Tissue Viability Nurse was also called upon when required for advice. The provider had employed a physiotherapist who provided physiotherapy to people to enable them to maintain and improve their general mobility especially after operations or injury. One person told us "I get her for a 1:1 for half an hour. I go upstairs and down stairs, we go outside, up the front steps and might go down the other side. Keeping my mobility helps me keep my independence." A physiotherapy room was located on the ground floor, so people had the privacy required to receive treatment.

Staff used a dairy and a communication book to relay information between shifts. Daily handover meetings were held to ensure continuity care through the sharing of information.

The home was large and well kept. The décor was fresh and clean. People's room's varied in size but all were personalised with people's own belongings. They were light and airy and comfortable. A refurbishment programme was underway to provide each person with their own wet room. Currently all rooms had ensuite facilities. Bathrooms and toilets were also available. The location of the home overlooks the Vale of Aylesbury and has spectacular views from the front of the home. People told us they enjoyed the views and spending time in the well maintained gardens and on the patio area.

Good

Is the service caring?

Our findings

People described the staff as caring, very helpful and supportive. One person recovering from major surgery told us “They have been very kind and supportive to me. In the beginning it was very hard… they treated me with the utmost kindness and support. I had all the help I could possibly have.” Another person told us about the provider being visible and present in the home; they said “When she asks us she really wants to know that we are alright.”

We observed good care practices throughout the home. We observed one person being supported with eating their lunch in their room by a member of staff. The staff member was familiar with yet respectful of the person they were supporting. They explained what they were doing and what the food was. They asked if the person wanted more or had had enough to eat. They were kind in the conversation with the person and it was meaningful. The person asked them questions which they answered and from their body language they appeared relaxed and comfortable with the staff member.

We saw that staff listened to people when they were talking to them. We observed one person being assisted in their wheelchair, the staff member who was supporting them gained the attention of a senior member of staff, telling them the person wanted to speak with them. The senior member of staff lowered themselves to the eye level of the person and engaged in a discreet conversation. They listened to the person and made reassuring gestures such as stroking their arm when speaking to the person.

One person told us they were particularly impressed with the care at night they told us “The night nurses are particularly good.....They will creep in and check on you.....last night was a bit colder...I went to bed with a spare blanket over my feet and when I woke up this morning they had been in and pulled it over me. I hadn't done it.”

We saw other staff laughing and joking with people. People clearly enjoyed the company of the staff, who appeared to have time to talk to them and respond to their needs.

People’s dignity was maintained by staff knocking on people’s door and waiting before entering. At mealtimes people were given napkins to protect their clothes. Staff referred to people by addressing them as Mr or Mrs Staff were referred to by their first names. Where people preferred to be called by their first names this happened. One person told us they felt respected by staff when they referred to them as Mr X. Another person told us how staff respected their privacy by closing doors and curtains when assisting them with personal care; they said “I'm very impressed with all the staff. Everyone knows us all; we are made to feel like real people and treated with respect.”

People told us they were involved in how their care was planned and delivered, one person told us they discussed their care with staff, who listened and complied with their requests. If at any time they wished to discuss their care they felt they could do this with the nurse or the provider.

Documents showed regular meetings were held with residents to discuss topics of interest about changes in the home and ideas people had about how the home could be improved.

The home had a relaxed and comfortable atmosphere. People were afforded the comfort of their own rooms with the extra benefit of spacious communal rooms, which were in keeping with the history of the house. Housekeeping and hospitality staff along with nursing and care staff were available to meet people’s needs. People appeared relaxed and familiar with their surroundings and told us they appreciated the aesthetics of the home.

Good

Is the service responsive?

Our findings

People told us they were included in the planning of their care, and could make decisions and choices about how it was delivered. For example, what time they got up and went to bed each day, where they ate their meals and whether they joined in activities or not.

One person described to us how they and their family had been contacted prior to moving into the home, to establish their needs and to agree how their needs would be met. The conversation covered their medical history, background and details of the assistance and support they needed. Other people had assessments completed before they arrived in the home and where appropriate information was shared with the home from other professionals, for example discharge summaries were provided for people leaving hospital.

Documents related to the care provided and associated risks were difficult to navigate. Records were sometimes duplicated on different forms and information was not easy to obtain. The nurse in charge was in the process of developing records to address this shortfall. This would minimise the risk of unsafe care being administered to people.

It was clear from talking to staff they knew about the people they were caring for, their likes and dislikes. Similarly the people we spoke with knew about the changes that had taken place in the home and how the provider was managing these changes. For example, one person told us how an administrator had left and the provider was taking over the role. It was obvious there was clear and open dialogue between the people in the home and the staff. Staff spoke about the home providing an environment where people could be as comfortable and as independent as possible. One staff member told us "Everything is done and geared to make residents happy." One person living in the home said "I can't imagine I would want to go anywhere-else….It's a comfortable and comforting place to be in."

People were supported to take part in activities. The home had an activity lead and an activity assistant, their role was to provide activities and outings which were of interest to the people living in the home. People spoke positively about the wide range of activities on offer. One activity organiser held a morning session on the day of the inspection. This was "What the papers say." One person told us they really valued and enjoyed this session. People told us about outings to the theatre, pub and shopping. There was a rota of planned activities as well as on an ad hoc arrangement. Activities included a good range of quizzes, board games, word games and similar activities. Several part completed jigsaws were laid out in halls and common areas.

The home provided DVD's in the drawing room and also took people to the cinema. There was a good demand to watch "special events" on the TV in the drawing room and these include major sports matches and the Proms. A knitting circle, arts, crafts sessions and adult colouring books had become quite popular. A monthly visit from a speaker from the Workers Education Association was well received by some people. A vicar and priest provided holy communion on a monthly basis or more frequently as required. We were told one person who was usually cared for in their room was supported to attend their grandchild's wedding recently. In addition and in order to protect people from social isolation families and friends were welcomed into the home. All the bedrooms were equipped with large format direct dial phones. This meant people could maintain contact with their family and friends when they wanted to.

One person told us how they used to belong to a music society before they moved into the home. They particularly enjoyed when a pianist came to the home and played a variety of music from classical to light popular music. They described the activities as "Excellent".

Another person told us of their experience of coming into the home. "This is my first time in a "home" and I've been very happy and content and they also put on a good programme of activities. The dining room is beautifully served like a high class hotel." A visitor told us "I get a very nice welcome and I am always offered a cup of tea or coffee and there always seems to be a very nice atmosphere here".

People told us they knew how to complain but they had not had any need to do so. Four complaints had been made in the last year; records showed these had been explored and responded to in a timely way. Compliments had also been received. People were able to provide feedback to the provider about the home either through direct contact with the provider or through residents meetings. Minutes showed actions had been taken

Good

Is the service responsive?

following the feedback people had given, for example including dishes on the menu. Historically questionnaires had been sent out to staff, residents and relatives. None had been sent out recently, but this was under consideration by the new manager.

Requires improvement

Is the service well-led?

Our findings

One person told us because the home was run by an independent organisation and not a large company they had been able to "put their stamp on it." They explained that the provider was keen to ensure the care being provided along with the "marvellous surroundings" made the experience of living there the best they could have. Other people told us they thought the home was well managed.

At the time of the inspection there was no registered manager in place, however, a new manager had been employed and commenced employment between the first and second day of the inspection. The provider told us the new manager would be registering with the commission to be the registered manager. People told us how they observed the provider in the home frequently helping out. It was clear from our discussions with the provider they had a good knowledge of the people living in the home and their needs. Comments about the provider included "She is an extremely good example and chases the other staff to make sure they are doing things right. She knows how to handle staff.....kind but firm." However, by their own admission the provider had no nursing knowledge. A clinical lead and senior nurse along with nursing staff were in place to provide care and advice in this area.

Without an effective manager in place it was evident the different aspects of the running of the home had not been monitored, and as a result improvements had not been made. For example, care plans and associated records were not appropriately recorded. Staff training and supervision had not been carried out, monitored and recorded. Checks for new employees had not always been carried out or accurate records kept. This placed people at risk of harm from staff who had not been employed safely or who had not been supported or trained sufficiently to carry out their role.

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

Staff told us there was a fair and open culture in the home. The provider told us this is what they believed to be the case. From our experience of speaking with people, staff and the provider it appeared that communication was honest and open. The provider was not afraid to challenge the opinions of staff but they were equally sensitive in their approach when needed. Most staff knew how to raise concerns about practice and told us they would feel comfortable to do so. The provider was approachable and staff appeared at ease in their presence.

On the provider's website they state "Our main objective is to create an environment where our residents can enjoy their independence with premium quality care. By valuing the needs of the individual, we are able to offer personalized care and enable our residents to do as thy please, living the life they choose to the agenda that suits them. Along the way we will do everything we can to provide assistance and companionship whenever required." It was clear from our observations the staff were aware of this vision and promoted these aims.

Staff appeared to be busy but relaxed in their approach to the tasks they had to complete. We met with the new manager and the provider on the second day of the inspection. The new manager had been in post for four days. During our discussions about the home and the inspection the provider offered the new manager the resources needed to ensure improvements were carried out in line with the concerns we had raised and to drive forward improvements.

Staff were clear about their roles and responsibilities and who they were accountable to. They spoke positively about the senior staff and the support they offered. Staff told us they worked as a team and supported each other. It was evident from what staff said there was some anxiety about the changes that were taking place in the home, with new personnel and new recording methods being introduced. From our discussions with the manager it appeared support would be available to staff moving forward, and their intention was to provide a well-managed service.

Checks had been carried out to ensure the quality and safety of the service was monitored. Health and safety checks had been completed, servicing of equipment and testing of electrical equipment. There was a fire safety risk assessment in place and regular fire drills were carried out along with testing of the fire equipment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care because of inadequate care planning and risk assessments. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who use services and others were not protected against the risks associated with unsafe recruitment processes. Regulation 19 (1) (a) (b) (c) (2) (a) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17 (1) (2) (a) (b) (c) (d) (f)