Hodge & Wilson Ltd

The Pines Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Pines Residential Home is a residential care home providing accommodation and personal care to up to 24 older people. At the time of the inspection, there were 20 people living in the home.

People's experience of using this service and what we found
Although people told us they felt safe living in The Pines, we found that the environment was not always safely maintained and individual risks to people were not always accurately assessed. Not all concerns had been referred to the local safeguarding team as required. At the last inspection, the provider was in breach of regulation regarding the management of medicines and we found that they were still not managed safely. Safe recruitment practices were not all adhered to and there was not always enough staff on duty to meet people's needs in a timely way.

People were not always supported to have maximum choice and control of their lives as not all required applications had been made to deprive people of their liberty. Although staff supported people in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice as consent was not always sought and recorded in line with the principles of the Mental Capacity Act 2005. There were no formal systems in place to support staff in their role and not all staff had completed training necessary to ensure they could support people effectively. People told us they had enough to eat and drink, but there was very limited choice available.

The provider had not acted on risks they had previously been made aware of and this did not demonstrate a caring approach. Permanent staff knew the people they supported well. Staff interacted well with people and spoke with them kindly, but people's dignity was not always maintained. People were not provided with any written information regarding the service to help them make decisions regarding their care and their feedback about the service they received, was not sought.

Care plans were not detailed enough, and did not always reflect people's preferences, to enable support to be provided based on their needs and wishes. There was a lack of activities available and people told us there were no opportunities for them to be supported out in the local community, for trips or events. A policy was in place regarding complaints, but information on how to make a complaint was not advertised within the home. However, people told us they felt able to raise any concerns they had with staff or the manager. People told us their family members could visit at any time and would always be made welcome.

There was a manager in post, but they had not yet applied to become registered with CQC. Systems in place to monitor the quality and safety of the service were not effective and there was a lack of oversight by the provider, to ensure people received good care. CQC had not been notified of all reportable incidents or events that had occurred. Records regarding people's care was not stored appropriately and several records requested during the inspection could not be located.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (Report published 11 December 2018) and there was a breach of Regulation 12 identified.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, not enough improvement had not been made and the provider was still in breach of regulation 12 and several other breaches were identified.

Why we inspected
The inspection was prompted in part due to concerns received about the quality and safety of the service being provided. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to the management of medicines, how people's consent was sought and recorded, staffing levels, safe recruitment of staff, person centred care and the governance of the service at this inspection.

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

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.

We will also meet with the provider to discuss the issues identified during the inspection and request an action plan to establish what actions they plan to take to improve the quality and safety of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

The Pines Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was completed by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Pines Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager in post, but they had not yet applied to become registered with the Care Quality Commission. This meant that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all the information we had received regarding the service since the last inspection. We received feedback from the local authority quality team about the concerns they had identified in the service. The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with ten people who used the service about their experience of the care provided and four relatives who visited the home during the inspection. We spoke with the manager, chef, activities coordinator and three other members of staff. We also spoke with a visiting health professional

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including audits, staff training records and policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At the last inspection we found the provider to be in breach of regulation as medicines were not always managed safely. During this inspection, we found that sufficient improvements had not been made and the provider was still in breach of regulation regarding the management of medicines.

- Medications had not been booked into the home accurately, so it was not possible to know if the correct amount of medicines were available for people, or if they had been administered appropriately.
- Records regarding the administration of medicines were not accurately or comprehensively completed, such as those for creams and medications prescribed as and when required (PRN). PRN protocols were not in place to guide staff when people may require this medication to be administered.
- Not all staff were aware of the agreements in place to administer one person's medicines covertly (hidden in food or drink), to ensure they received the medicines they required. This had led to the person not having their medicines for several days as they refused it due to confusion.
- Not all medicines were stored securely. We saw one prescribed cream in a person's bedroom, that should have been stored in a fridge.
- Although staff had completed training in the management of medicines, they had not had their competency assessed. Since the inspection, the manager provided a newly completed competency assessment for one staff member.

Failing to manage medications safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- Risks in the environment had not all been assessed to help ensure it remained safe for people. For example, no fire risk assessment was available and there were no risk assessments for the portable heaters in people's bedrooms. One bedroom did not have a window restrictor to prevent falls from height and a fire door was wedged open, preventing it from closing in the event of a fire. The manager rectified the issue with the fire door during the inspection and arranged for a window restrictor to be fitted.
- Staff had not been trained in the use of fire evacuation equipment and not all staff had received fire safety training.
- When individual risks to people had been assessed, they had not all been completed accurately.
- One person did not have any care plans in place despite having a significant medical issue. This meant that not all staff may have the necessary information to meet the person's needs.

● Accident and incidents were not properly recorded, reviewed or acted upon to reduce risk. Not all accidents were recorded within the accident file and no audits were undertaken to look for trends to help reduce the risk of future incidents.
● There was little evidence that unexplained injuries had been investigated appropriately.
● Referrals had not been made to other health professionals when required, such as when people had sustained multiple falls.

Lack of robust risk management systems is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe in the home. Their comments included, "I feel safe because I am well looked after. [Staff] treat me well I can't fault them" and "I feel very safe here. I can't use my legs and I depend on [staff].

Staffing and recruitment
● Safe recruitment practices had not been followed. There were no references available in any of the staff files we viewed. All had a DBS but as there were no start dates recorded, we were unable to establish if these checks had been completed prior to staff starting in post.
● There were not always enough staff on duty to ensure people's needs could be met in a safe and timely way. Overnight, there were usually only two staff on duty to support the 20 people living in the home. The manager told us half of these people required support from two members of staff. This meant there would be regularly be no staff available within the home, if the two staff were supporting one person.
● People's feedback about staffing levels varied. One person told us, "I am not sure if there are enough staff, but one day last week we had to have tea in the lounge because there were only two on and they brought the food to us." Another person said, "Well I get a good scrub in a morning, but showers are a problem because of availability of staff." A relative told us, "The carers seem to change a lot and there are a lot of agency staff."
● Staff also told us there were not always enough staff, often due to sickness. The manager told us they were in the process of recruiting more staff and three care staff were due to start in post later that week.
● At regular times throughout the day, there were no staff in the two lounges. During lunch, there were times no staff were in the dining room and both the maintenance person and the hairdresser supported people as no care staff were available.

Failing to ensure sufficient staff are available who have been safely recruited, is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● There was a strong malodour evident throughout the home. The manager told us they were looking into replacing the flooring, which they hoped would reduce the malodour.
● There were no hand washing facilities available in the staff toilet and staff had to use the sink in the laundry which was also used to hand wash or soak people's clothes. Communal bathrooms contained liquid soap and paper towels in line with infection control guidance.
● People told us they felt their home was kept clean.
● Staff had access to disposable gloves and aprons to help prevent the spread of infections.

Systems and processes to safeguard people from the risk of abuse
● Not all incidents had been referred to the local safeguarding team as required.
● A safeguarding policy was in place to help guide staff and they told us they would inform the manager of

any safeguarding concerns.

- A whistleblowing policy was also in place that staff were knowledgeable about.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Although staff told us they felt supported in their role, there were no formal support systems in place.
- There was no recorded induction for staff. One staff member told us they were showed around the home and informed of protocols, but this was not recorded. The provider's induction policy states all staff will complete an induction based on the principles of the care certificate.
- There were no regular supervisions in place to enable staff to discuss their role and any issues they had, or training required. There was no evidence of staff having received an annual appraisal.
- Records showed that not all staff had received training necessary to enable them to meet people's needs safely. For instance, despite a number of people living with dementia in the home, very few staff had received any training to ensure they could support those people effectively.

Lack of staff support systems and adequate training is a breach of Regulation 18 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

- Consent was not sought and recorded in line with the principles of the MCA.
- When people were able to consent to their care, there were no records to show their consent had been sought.
- Although some applications had been made appropriately to deprive people of their liberty, we found that other applications were required. There were no mental capacity assessments completed prior to applying for a DoLS to show people's ability to consent to living in the home had been assessed.
- When capacity assessments were completed and showed people lacked capacity, best interest decisions

were not recorded accurately. For instance, one person's best interest decision reflected that the mental health team had been involved in the decision, but the manager confirmed they had not been involved.
● One person's care file reflected their family member held power of attorney regarding health and welfare, but there was no evidence available of this.

Failing to gain consent in line with the principles of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they did not always enjoy the food and they had limited choice in the meals available. Comments included, "The food is just okay. Breakfast is just cereals and toast and we get a main meal at lunch time. There are no choices, if I don't like it there are no main alternatives just sandwiches. It's all prepared so I just tend to sit down and eat it", "The breakfast is basic cereal toast crumpets. If you asked for eggs, bacon or sausage they would tell you where to go. Food today wasn't good but it's just satisfactory at other times" and "Let's just say the food could be improved."
● When people required their food and drink intake to be monitored, records were not always available to show this had been done. Records completed did not always reflect that plans recommended by the dietician had been followed. For instance, one person required three fortified milkshakes per day, but the records only reflected one most days.
● The chef was aware of people's dietary needs and provided suitable meals to accommodate these needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff liaised with other agencies, but referrals for specialist advice were not always made in a timely way.
● People told us staff supported them with their health needs and arranged for the doctor to visit if they were unwell.

Adapting service, design, decoration to meet people's needs
● People's bedroom doors contained their name and picture to help locate their rooms. Some pictorial signs were available around the home, as well as an information board showing the date, weather etc, to help orientate people.
● People were encouraged to personalise their rooms and we saw that rooms contained people's own furniture, pictures and other belongings.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Records did not always show that people's needs had been assessed prior to them moving into the home. This meant staff may not have the information necessary to enable them to know and meet people's needs.
● People's care plans lacked sufficient detail about their needs and risks in order for staff to ensure all their needs were met.
● People's medicines were not managed in accordance with best practice guidance, such as NICE or the Royal Pharmaceutical Society of Great Britain.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- The provider had not acted on risks previously identified risks, such as those highlighted by the local authority, to ensure people remained safe in the home. This does not demonstrate a caring approach.
- There were not always enough staff available to ensure people had their needs met in a timely way. For instance, there were a lack of staff available to support people during lunch. One person told us, as they had to wait for staff support to get up of a morning and have breakfast, they were often not hungry at lunchtime as they had not long had breakfast.
- People told us staff were kind to them and treated them well. Their comments included "The staff are very good with me I can't complain about them. They do their best to help me", "I have a good laugh and a joke with the staff they are alright", "They look after me very well", "I am treated properly with respect. The staff know me very well and what I need and do their best to help me."
- Permanent staff knew people well, including their needs and preferences. Staff spoke about the people they support in a warm and genuine way.

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

- People were not provided with any information regarding the home, services available, or what to expect, when they moved into the home.
- There were no systems in place to gather feedback from people, such as quality assurance surveys or resident meetings.
- The manager was not aware of any local advocacy services, should people need these to support them with decision making, but told us they would source this information if required.
- There was no evidence that people had been included in the reviews of their care plans, to help ensure they remained effective to the individual.

Respecting and promoting people's privacy, dignity and independence

- People told us they felt they received care that maintained their dignity and privacy. One person told us, "When they help me have a shower they make sure the doors are shut and they cover me up when necessary." However, during the inspection we saw that people's dignity was not always maintained. For instance, one person was sat in the lounge under a hair dryer for a period of time, another person was assisted to shower with the door left open, then wheeled in a chair through two lounges, wrapped only in towels. This did not promote people's dignity.
- We observed staff knock on people's bedroom doors before entering and staff told us they always asked people what support they wanted.

- The provider had policies regarding both choice and confidentiality, to help guide staff in these areas.
- Records containing people's private information were stored securely.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People were at risk of receiving care that did not meet their individual needs because their care plans were not sufficiently detailed and some contained conflicting information regarding people's needs. One person did not have any care plans in place to inform staff of their needs or preferences.
- Care plans were not always followed. For instance, when people's care plan showed they required their weight to be monitored each week, the manager was unable to find the records to evidence this was completed.
- There was very limited information regarding people's preferences and no history or pen picture to help staff get to know people as individuals.
- Care plans and risk assessments had been reviewed, but these reviews were not meaningful or effective. There was no evidence of the person's involvement and information about people's needs and care plans were not always properly updated to reflect changes.
- Some people had do not resuscitate orders in place, but there were no personal end of life care plans in place to advise staff of people's end of life wishes and preferences.
- People's comments showed they did not always receive a service that was based on their individual needs. One person told us, "I think the regular staff are quite good, but we get agency staff coming in and they are not practised in helping us and they don't know what I need or want." Another person told us, "I played the piano and the accordion, and it was part of my life", but there had not been any opportunity for this person to continue with this hobby they had enjoyed.

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

- People told us there were not always enough activities available. An activity coordinator was employed, but they also provided care to people each morning. If it was not too busy, they could then provide activities later in the day.
- We observed chair exercises taking place during the inspection. One person told us, "There are not many activities going on. I wasn't aware of any exercises going on this morning." Another person said, "I would like more activities especially more music because it keeps you alive. There is not much going on and I've not heard about any trips out and sometimes it's too cold to go in the garden." A relative told us, "I just wish there was more for her to do and there isn't much choice with the food and no trips out and when it's good weather they don't even take them out in the garden."

Failure to ensure care met people's individual needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us their family members could visit at any time and were made welcome.
● People's religious needs were known by staff and a local church visited each week to provide a service for those who wanted this.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy, but this was not displayed within the home for people to refer to. Most people however, told us they could speak to staff if they had any issues.
● A complaints log was in place, but this had not been updated since the manager had been in post. The manager however, told us they had received some 'grumbles' that they had resolved. Complaints recorded in the log did not reflect an outcome or whether the complainant was happy with the outcome.

We recommend the provider reviews and updates its complaints procedures to ensure there is an accessible and effective system for managing complaints.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans for some people provided information regarding their communication needs, such as whether they wore glasses or a hearing aid.
● The manager told us one person had specific communication needs, as they were hard of hearing and in order to communicate effectively, staff used a notebook to write things down.
● Information regarding the service, such as complaints policy and contracts, had not been offered in any other formats to support understanding and effective communication.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a manager in post, however we had not received an application for the manager to become registered with the Commission.
- CQC had not been notified of all reportable incidents or events that had occurred.
- Following recent visits from the local authority quality assurance team, the manager had been advised that improvements to the service were needed. We found however, that many of the concerns identified had not been fully addressed. This did not demonstrate effective management of the service.
- The systems in place to assess and monitor the quality and safety of the service were not effective. The checks completed did not identify all areas of concern we highlighted during the inspection.
- The checks did not cover all aspects of the service, such as care planning, accidents and staff recruitment. When checks were completed, they did not always accurately identify areas for improvement. For instance, the PRN medication records had been audited, but failed to recognise several errors within the records.
- The manager was unable to locate a number of records requested during the inspection, from records regarding people's care, to certificates regarding the safety of the building. We observed records regarding people's daily care, assessments and accidents to be stored inappropriately in a box, mixed with other records that had been ripped and appeared to be ready to be disposed of. The manager told us there was not currently an effective system to manage records within the home and evidenced during the inspection.

Lack of effective governance systems to ensure the home is safely managed, is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The manager told us the provider visited the home approximately every six weeks, however there was no evidence to show how they maintained oversight of the service to ensure people received good quality care.
- Relatives told us they were informed of any accidents or incidents involving their family member.
- Not all accidents and incidents had been referred to the local safeguarding team as required.

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

- Although staff felt supported in their roles, there was a lack of systems in place to provide formal support to staff, such as induction, supervisions and appraisals.

● Several concerns were identified at this inspection with regards to the service. These impacted on the ability of the service to provide good outcomes for people.
● Most people told us they knew who the manager was and could raise any issues they had with them.
● The atmosphere at the home was friendly and relaxed. Staff were observed to work well together as a team and they told us teamwork was one of the best things about working at The Pines.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were no systems in place to engage with people living in the home or seek their feedback regarding the service they received.
● Minutes from one staff meeting were available. They did not show that staff had the opportunity to discuss any issues or provide feedback on any of the topics covered.

Working in partnership with others
● Advice from other professionals was not always followed, such as recommendations from social worker following a safeguarding investigation, or dietary advice from the dietician not being recorded as provided.
● A visiting health professional told us staff communicated well with them and made referrals appropriately.
● The manager told us they engaged with local initiatives to help improve the service, such as the local registered managers forum and 'tele triage', which is an on-line health advice service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not planned or provided to meet people's individual person centred needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not sought and recorded in line with the principles of the Mental Capacity Act 2005. Not all applications to deprive people of their liberty had been made as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the environment and individual risks to people had not all been assessed appropriately. Medications were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality and safety of the service were ineffective.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not evidenced to ensure staff were suitable to work with vulnerable people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff on duty to meet people's needs in a timely way. There was a lack of formal support systems in place to support staff in their roles and not all staff had received necessary training.