Medical Resources Worldwide Limited

The White House Nursing 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?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection was carried out on 18 June 2015 and was unannounced.

The White House Nursing Home provides accommodation, personal and nursing care for up to 67 older people. There was a registered manager in post. 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 and associated Regulations about how the service is run.

When we last inspected the service on 12 November 2014 we found them to not be meeting the required standards and they were in breach of regulations in relation to care and welfare, privacy and dignity, safeguarding people from the risk of abuse, management of medicines,

Summary of findings

respect and involving people and consent. At this inspection we found that they had still not met the fundamental standards and were in continued breach of regulations detailed above and in addition for their recruitment practices and not displaying their rating from the last inspection..

Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection the appropriate applications had not been made to the local authority in relation to people who lived at the service and people may have been unlawfully deprived of their liberty. The manager and staff were not clear of their role in relation to MCA and DoLS and how people were at risk of being deprived of their liberty.

People told us that they felt their needs were met. However, staff were not always able to tell us about people's individual needs. Care plans and records were not clear and had gaps throughout.

Risk assessments were not in place in all cases, and those in place were not reviewed. Medicines were not managed safely. People told us they felt safe and staff had an understanding in relation to safeguarding people from the risk of abuse. However, some issues that should have been investigated and reported were not.

People had a choice of food and were supported to eat and received regular support from health care professionals.

People and staff felt at times there was not enough staff. Recruitment practices were not always robust and did not ensure the relevant pre-employment checks were sought or on the person's file. Staff received training relevant to their role and had one to one supervision regularly.

There were inadequate monitoring systems in place. The manager had not provided the CQC with an action plan following the previous inspection and had not taken the necessary steps to improve the quality of the service and were in breach of Regulations 9, 10, 11, 12, 13, 17, 19 and 20a of the Health and Social Care Act (Regulated Activities) 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?
The service was not safe.

People were not supported to ensure their needs were met safely.

Staff knew how to recognise and report allegations of abuse. However, issues that should have been investigated and reported were not.

People's medicines were not managed safely.

Staff who worked at the service did not always go through robust recruitment process.

Inadequate

Is the service effective?
The service was not effective.

People were not supported appropriately in regards to their ability to make decisions and the service did not comply with MCA 2005. The service had not applied for DoLS where needed.

Staff received regular supervision and training relevant to their roles.

People were supported to eat and drink sufficient amounts.

Inadequate

Is the service caring?
The service was not always caring.

People felt that communication in the home needed improvement.

People who lived at the home were not involved in the planning and reviewing of their care.

Privacy, dignity and respect were not always promoted throughout the home.

Requires improvement

Is the service responsive?
The service was not always responsive.

People who lived at the home and their relatives were confident to raise concerns, however, there was no record of any concerns being raised.

Feedback was not sought or responded to.

People received care that they felt met their individual needs.

People's care plans were not fit for purpose as they held inadequate information.

Requires improvement

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

There were no systems in place to monitor, identify and manage the quality of the service.

The manager had not ensured the service met the fundamental standards.

People who lived at the service, their relatives and staff were positive about the manager.

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The White House Nursing Home

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This visit took place on 18 June 2015 and was carried out by an inspection team which was formed of two inspectors. The visit was unannounced.

Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us. Before and following the last inspection, we asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service which includes the service does well and improvements they plan to make. However, we did not receive this. Following the last inspection the provider was required to send us an action plan detailing how and when they would resolve the identified issues. However, they did not develop or submit an action plan.

During the inspection we spoke with seven people who lived at the service, five relatives, eight members of staff and the registered manager. We received feedback from health and social care professionals. We viewed five people's support plans. We viewed four staff files. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Inadequate

Is the service safe?

Our findings

When we inspected the service on 12 November 2014 we found that the service was not meeting the requirements in relation to safeguarding people from the risk of abuse. At this inspection we found that they had not fully addressed this shortfall and staff were still not fully aware of how and when to report allegations of abuse. For example, unexplained bruising or comments regarding poor care. We saw records of unexplained bruising which had not been raised as a concern. We also saw a completed survey from a person who lived at the home which stated they did not receive the care they needed. The manager and staff dismissed these comments as "That's just [person]." They were unable to tell us at what point these comments would initiate an investigation to make sure the person was safe and having their needs met.

This was a breach of Regulation 13 of the Health and Social Care Act 2014.

When we inspected the service on 12 November 2014 we found that the service was not meeting the requirements in relation to ensuring people received safe care that met their individual needs. At this inspection we found that these concerns had not been resolved.

People were using bed rails without the required bumpers to minimise the risk of people trapping their arms or legs in the bed rails. We viewed the bed rail risk assessment which stated bumpers were to be used when bedrails were in place. Staff told us they did not know why bumpers were not being used and that they should be used. In some bedrooms without bumpers in use we saw they had the bumpers folded up on top of the wardrobe, others did not have any available. This meant that people were at risk of entrapment due to staff not using the equipment safely.

People did not always have the appropriate or clear risk assessments in place. We noted that where a person had a recurrence of falls, their risk assessments were not updated. Staff were unable to tell us what individual risks were for people and how they ensured these risks were reduced. For example, in relation to falls, moving and handling, hydration and pressure care. The manager told us that neither they, the provider or the staff monitored accidents or incidents to identify how risks to people could be reduced. This meant that people were not always kept safe from unnecessary risk to their health and welfare.

People were at times transferred in the hoist by one staff member. Staff told us that where people were able to 'help' with the use of the hoist they were able to do the manoeuvre on their own. One staff member said, "A few residents have capacity and if they feel safe I can use the hoist on my own if they haven't got capacity will hoist in two`s." Staff told us that training stated that the hoist should be used with two staff members. We saw staff using the hoist on their own when people did not have capacity and were unable to assist with the manoeuvre. One staff member said, "The training said two but sometimes it is manic." The manager told us that they expected two staff members to use the hoist. However, as this guidance was not always followed, people's safety was put at risk.

These concerns meant that this was a breach of Regulation 12 of the Health and Social Care Act 2014.

When we inspected the service on 12 November 2014 we found that the service was not meeting the requirements in relation to their management of medicines. At this inspection we found that they were still not meeting the standards.

The quantity of medicines kept in the home was not correctly recorded. As a result we were unable to verify if people had been receiving their medicines in accordance with the prescriber's instructions. We saw that nurses had adapted a practice of recording people's anti-coagulant medicines which left a chance for error. Variable dose medicines, such as pain relief which can be given as one or two tablets, did not have the quantity of medicines administered recorded and there were also gaps on medicine records for those to be given at regular times. We found some of the medicines that these gaps related were still in the blister pack, others were not. The nurse responsible had not made an entry to state whether they had been given or not. There were no monitoring checks of medicines, records or stock and the manager had not completed any audits. In addition, nurses were not assessed to make sure that they were competent to administer medicines.

Due to the unsafe use of bedrails, the lack of effective risk management and the management of medicines, this was a breach of Regulation 12 of the Health and Social Care Act 2014.

Inadequate

Is the service safe?

People told us that they felt safe at the home. One person told us, "I feel very safe." Relatives also told us they felt the home was safe.

People who lived at the home and their relatives told us they felt there was sufficient staff to meet their needs. However, people also told us that they sometimes had to wait for assistance. One person said, "You press this things [call bell] but it doesn't always do any good, sometimes staff come and say I'm not on your section. Why can't they just help you?" Another person told us, "Most of the time there's enough staff." A relative told us, "There is usually someone [staff] about."

During the inspection people had their call bells answered promptly. We saw that people received support with personal care in a timely manner. One person told us, "The night staff get me up into my chair and then I wait for the day staff to help me dress." They confirmed this was done at times that suited their needs. We noted that during the day there were periods of time when people were left without staff supervision in communal areas, some of whom were at risk of falling. However, on one occasion we heard the nurse direct a staff member to the lounge to ensure people were supported. Health care professionals also told us they felt there were enough staff to meet people's needs.

Staff told us they did not feel there were sufficient numbers to meet people's full range of needs. They told us there was time to do basic care tasks but not to spend time talking with people. One staff member said, "I like doing baths in the afternoons as you can actually sit and talk to people rather than rushing." We viewed the rota which showed that when staff were off sick, their shifts were not covered and the home did not use agency staff. The manager said, "Even if they are short staffed they are still adequately staffed." One staff member told us, "Sometimes staff cancel shifts or call in sick and it is so difficult." The manager was unable to tell us how they assessed dependency levels to ensure that staffing numbers were appropriate and that there were enough staff to meet people's needs.

The recruitment process was not always robust. We saw staff files that had gaps in employment history, missing criminal record checks and missing written references. Where references were on file, these had not been verified and were not always from the last employer. We also saw that there were no records of visa's that had been reapplied for, or a record that an update of a nurse's pin was applied for. The manager was able to obtain an up to date visa for a staff member after it had been highlighted by us. There was not a checklist to ensure all relevant and required pre-employment checks were completed and documented and the recruitment files were not checked by the manager to ensure people were fit to work with at the home.

This was a breach of Regulation 19 of the Health and Social Care Act 2014.

Inadequate

Is the service effective?

Our findings

When we inspected the service on 12 November 2014 we found that the service was not meeting the requirements in relation to the MCA and DoLS. At this inspection we found that they were still not meeting requirements.

People were being unlawfully restrained without a DoLS application being made. Forms for people to give consent to the use of restraint were not always signed and when they were, it was by a relative. There was no explanation of the authority the relatives had to sign on behalf of their family member. Types of restraint being used included the use of gates on bedroom doors, chairs people could not get out of and key coded locks on external doors which prevented people from leaving the service independently. Staff told us that the gates were used for "A bit of both" when asked if they were to stop the person coming out of the room or to stop people going in. Another staff member told us, "I think families ask for it, due to the walkers." When we last inspected the service we informed the manager that these applications must be made to ensure they complied with legislation.

Staff had limited understanding of their role in relation to the MCA 2005. One staff member said, "We have to do decisions for the people who cannot make decisions." We saw that some decisions had been made with the involvement of family members and recorded as being in the person's best interests. However, the appropriate process was not followed and urgent authorisation for these decisions had not been sought. People's ability to make decisions was not always assessed, and when it was, it was not reviewed. One person had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) record in their care plan. There had been no capacity assessment carried out and the person had not been included in the making the decision about whether they wanted to be resuscitated. The manager and staff were unable to state whether or not the person had capacity to make this decision. The person had no immediate family and an independent mental capacity advocate had not been consulted.

This was a breach of Regulation 11 of the Health and Social Care Act 2014.

People told us that they had enough to eat and the food was good. They felt their dietary needs were catered for. One person told us, "I'm diabetic, so I have to watch what I eat." The chef told us that they make individual cakes for people with diabetes. The chef was passionate about cooking and described the different meals they prepared. They told us how they prepared food for people who needed a soft or pureed meal and how they fortified food for people who needed extra protein. However, we noted that the food choice was made the previous day and there was no visual prompt to support people who may not remember what they had chosen. We also found that lunch was served in order of the menu form rather than by table which left people sitting waiting while others on their table were eating.

People who were at risk of not eating or drink enough were on food and fluid monitoring charts. However, we noted that the amount of fluid people should be drinking was not identified and the amount consumed was not totalled at the end of each day to ensure people had drunk enough. Staff did not know what the amount should be for each person. One staff member told us, "I will be concerned personally if I saw that people had less than 400ml in a day." This is significantly less than people should consume. Another staff member said, "If I feel they are under the weather I will report to the nurses but it is a big home and I have to insist at times." We also saw that people did not have their nutritional risk assessed regularly and there were gaps in people's weight records. We also saw that people had stayed at the exact same weight for a number of months. The manager assured us that people were being weighed and the reason it was the same was due to staff rounding up the numbers to an even weight rather than recording people's actual weight. The manager told us that if they were concerned about a person's nutritional intake they would refer them to a medical professional. Health care professionals told us that the home ensured people's health was maintained and raised concerns with them if they felt a person was not drinking sufficient amounts.

People told us that they felt the staff were well trained. One person told us, "Very well trained." Relatives shared this opinion.

Staff attended training courses which covered relevant areas including safeguarding people from abuse, fire safety, moving and handling and infection control. However, we noted that although the nurses told us they observed staff practice to ensure they work in accordance with training, these competency assessments were not recorded. In addition, the manager did not record their competency

Inadequate

Is the service effective?

assessments of the nurse's practice. the lack of competency assessments had contributed to the provider not identifying the areas of concern that we found in relation to a lack in staff knowledge with regards to safe medicines management, moving and handling and also a gap in the understanding relating to MCA and DoLS.

Staff received regular one to one supervision with their manager to give them the opportunity to raise concerns or request additional training. Care staff told us that they felt supported by the manager and would go to the manager rather than the nurses. Nurses told us they felt supported by the manager.

People had regular access to health care professionals. We saw that there was a regular GP visit at the home and there had also been involvement with the mental health team, tissue viability nurse and chiropodist. Health care professionals told us that they felt the home was responsive to people's health care needs and called them when it was appropriate.

Requires improvement

Is the service caring?

Our findings

When we inspected the service on 12 November 2014 we found that the service was not meeting the requirements in relation to promoting people's dignity, privacy and treating them with respect.

At this inspection we found that some improvements had been made, for or example, closing bedroom doors. However, during our inspection we knocked on bedroom and toilet doors to enable us check on the environment and speak with people. On three occasions, care was being delivered, the door was not locked and the staff member did not speak to alert us that there was care in progress. This meant that people's privacy was not always promoted.

People who lived at the home and their relatives had not been involved in the planning of their care. A relative told us, "The reviews are a bit hit and miss." The plans did not reflect people's preferences, choices or life history. There were some 'This is me' documents which gave staff some details about people but these were not consistent in each person's care plan.

People were not always listened to. For example, we heard people asking for cups of tea and these requests were met by staff with comments including, "You've just had one with breakfast." And, "Tea round in an hour, do you want some juice." This did not ensure people felt respected and valued. We also heard people asking for the toilet and staff dismissing it. For example, A staff member asked the person, "Are you absolutely sure you want the toilet now?" The person repeated the request several times. The staff member walked away and another staff member approached the person repeating the same questions. After the person insisted to go the staff brought the hoist in and assisted the person to the toilet. This was 15 minutes after the initial request.

We observed people asking for support and heard staff respond with comments including, "I've only got one pair of hands you'll have to wait." And, "I'm busy, you'll have to wait." One person also told us that at times when they pressed their call bell they felt like a nuisance as staff sometimes minimised their need for assistance. They told us, "I called for them [staff] to open my curtains and [they] said, is that all you called for?" Another person told us when they asked for help they were told by staff, "I'm not on your section." They went on to say, "Surely they're all carers." In addition, we informed a staff member of a person walking in the corridor asking for assistance holding their continence product. The staff member's response to us was, "Oh god, again."

This was a breach of Regulation 10 of the Health and Social Care Act 2014.

Four people who lived at the service and their relatives told us that the staff were kind and caring. We observed that most interactions between staff and people were positive. One person told us, "They are very caring."

Requires improvement

Is the service responsive?

Our findings

When we inspected the service on 12 November 2014 we found that the service was not meeting the requirements in relation to making sure people received care that was responsive to their individual needs. At this inspection we found that they were still not meeting the fundamental standards and issues previously identified were not resolved.

People's care plans were not clear and did not contain up to date information. People told us that they had not been involved in planning their care needs. However, people who lived at the home told us they felt their needs were met. One person said, "They [staff] do everything you ask." Relatives of people were also positive about the care provided. One relative said, "The carers [staff] definitely know her." Another relative told us that when their relative started to need more support they had needed to point this out to staff but now said, "[They're] well taken care of."

However, staff were always not able to tell us people's individual needs and when they did, we noted they did not follow the care plans. For example, in one person care plan it was recorded they needed reassurance throughout personal care due to an historic event. When asked about a specific person a staff member supported they told us, "[They] needs to be fed and given fluids." "[They] stays in their room." The staff member was unable to elaborate on their specific risks or tell us anything about the person.

People only received personal care in the morning and not before going to bed. Staff confirmed that personal care was only carried out in the mornings and people did not routinely have a wash or clean their teeth before bed. One staff member said, "All personal care is done in the morning. If a resident is soiled I will assist, guide to the toilet but not routinely doing personal care in the evenings." We noted staff supported people without speaking with them at all.

People who were at risk of developing a pressure ulcer, dehydration, falls, and anxiety did not always have clear information on how to support them. When we asked staff, they were not always clear on how to support people and there was an absence of records detailing what care had been delivered. Care plans had not been reviewed and therefore may not have been accurate. This meant that there was a risk that people may receive wrong or inappropriate care for their needs.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2014.

The service did not always obtain and act on people's feedback. There had been no recent meetings for people, their relatives or staff to gain their views. One relative told us, "There used to be meetings but we haven't had one for a while." The manager told us that, "There have been no meetings since our last inspection." People who lived at the home, their relatives and staff were unable to give an example of when their feedback had been taken and had resulted in changes being made to the home. The manager was also unable to give us an example.

In May 2015 there had been a resident's survey completed. We saw that 50% of people had completed a survey. However, we saw that there were issues identified on these surveys that had not been investigated. The manager told us they had not seen the surveys. The staff responsible for the surveys told us they had not acted upon the information received. Some of the issues noted could have significantly impacted on their daily lives. For example, their care experiences, staffing and food concerns. The staff confirmed they had not acted on people's concerns or raised the concerns with the manager.

People told us they know how to make a complaint and that they would go to the manager. One person said, "[The manager] is very nice." The manager told us that they had not received any complaints. They told us they had received "Little things that crop up.", but they had not recorded them. This meant they were unable to monitor views of people to ensure they were acted on where appropriate.

As the service did not actively seek and respond to people's feedback, this was a continued breach of Regulation 17 of the Health and Social Care Act 2014.

People told us that there were activities provided at the service. On the day of the inspection there was a ball game going on and a sing-along in the garden. One person told us they enjoyed gardening which they had participated in, "Last year." Other people told us that the group activities were not something that interested them. One relative told us, "Activities are not great, the activity schedule

Requires improvement

Is the service responsive?

disappeared, it`s a shame as [relative] responds well to group activities." Another relative told us, "The activities in the week are very good but I think at the weekend everyone is bored." The manager told us that they were in the process of reviewing this with the possibility of an activity organiser being on duty one day over the weekend.

People were supported to go out for walks and shopping. One person was recently supported to attend a family function. The activity schedule offered a variety of things for people to do. These included arts and crafts, quizzes, memory games and cooking. The activity organiser told us that they were in the process of speaking with people to get to know their previous and current hobbies and interests.

Inadequate

Is the service well-led?

Our findings

When we inspected the service on 12 November 2014 we found that the service was not meeting the requirements in relation to systems being in place to assess, monitor and manage the quality of the service. At this inspection we found that they were still not meeting the fundamental standards.

Following our last inspection the provider was required to submit an action plan to detail the actions they would take to address the areas of concern found. The provider was also required to submit the provider information return (PIR) detailing what the service did well and the areas for development. In addition the service was also required to display the rating awarded to them at the last inspection. None of these actions had not been carried out.

Quality monitoring systems were not effective and did not monitor the standard of the service or lead to the necessary improvements. There had been no audits or monitoring carried out to review the issues identified at the last inspection and therefore there had not been any action plans developed to address the concerns identified. The issues identified included the standard of care provided, medicines management and ensuring legislation, in particular relating to MCA 2005, was complied with. We found continued breaches of regulation in these areas.

Care staff were clear of their role was, as were the nurses on their role. However, they saw their roles were separate and this meant for an unified team. Care staff were bypassed the nurses and went straight to the manager with any issues as there was no deputy in place. The lack of clear hierarchy and effective leadership from the nurses led to the fact that the manager needed to lead on all issues. The manager did not delegate tasks or guide people, relatives or staff to talk to the nurses. As a result, staff were not taking responsibility for any area of the home or quality of service provision.

The manager did not record any issues they dealt with on a day to day basis so was unable to identify trends and patterns to help improve the service. For example, if people complained about the food, missing laundry or when a relative raised that a person had dirty nails. There was no record of supervision of staff practice or assessment of competency to demonstrate that their was an overview of the staff performance but also their effectiveness as a team, even though staff, and the manager, told us they had raised concerns around this with the manager.. The service did not have a plan in place of how they monitored and improved the service. The manager told us that the provider visited the home around three times per week and spoke with people and checked the environment. However, there was no record of these visits and as a result, no information for us to review.

As the service did not actively seek and respond to people's feedback, this was a continued breach of Regulation 17 of the Health and Social Care Act 2014.

People who lived at the home, their relatives, staff and a health care professional were all positive about the manager. Everyone told us they knew the manager well and they were approachable. One person said, "[The manager] is always about." A relative told us, "[The manager] is very good." One person also told us that they saw the provider about the home regularly.

We saw that the manager knew people and their relatives well. People, their relatives and staff said the nurses were not as approachable as the manager. This meant that did not feel they could always go to the nurses with concerns or for support and advice. We spoke with the manager about this who told us, "It's because the nurses are busy carrying out clinical tasks and not providing care such as feeding someone." People us told that communication in the home needed improvement.

There were links to the local community with people being given support to access the local shops, family events and there were church services held in the home. People's family members and friends were encouraged to visit the home with the most recent event being a garden tea party. Relatives told us they were always made to feel welcome in the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not ensure care was always provided in a person centred way.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider did not ensure people were always treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not ensure the correct systems were followed in relation to obtaining consent and depriving people of their liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure people received safe care and treatment,**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not ensure people were safeguarded from the risk of abuse.**

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not ensure the systems in place effectively monitored and improve the quality of the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not always follow robust recruitment procedures.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments **The provider did not display their rating.**