Rearsby Home 5 Limited

Rearsby Home Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rearsby Home Limited is a residential care home providing accommodation and personal care. The service is registered to support up to 27 older people with a physical disability, dementia and mental health needs.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. There were 23 people living at the service at the time of the inspection, 22 received personal care.

Accommodation was split across two floors accessed by a lift and two stairwells.

People's experience of using this service and what we found
People were not always kept safe from the transmission of COVID-19. Government guidance for testing, visiting, admissions to care homes and the use of personal protective equipment had not been followed. Cleaning schedules did not evidence frequently touched areas were cleaned or deep cleans undertaken. People were not supported to socially distance and people's risks had not always been appropriately assessed and measures put in place to reduce them.

There was an absence of safeguarding systems and processes and records. Staff had not always been safely recruited.

Staff had not been equipped with the skills and knowledge they required to undertake their role effectively. Staff training was either overdue or had not been undertaken. Some staff had not received an induction to introduce them to their role. Staff had not received regular supervisions to consider their development needs.

There were widespread failings of the leadership and governance of the service. Quality assurance systems and processes were either absent or failed to identify the concerns we found during the inspection. The registered manager and provider failed to ensure the action plan submitted following the last inspection had been implemented.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. Whilst we observed staff offer people choices, mental capacity assessments and best interest decisions for people that were unable to make choices had not always been undertaken. Where they had, they were not always fully complete.

We received mixed feedback from relatives about access to healthcare professionals. We received positive

about the food and observed people eating well.

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 (published 13 April 2021) and there were three breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to falls management, infection prevention and control, training and governance. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the delivery of safe care, consent, safeguarding, training, recruitment and the leadership and management of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below

Rearsby Home Limited

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by one inspector.

Service and service type
Rearsby Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 registered with the Care Quality Commission. This means that they and the provider are 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 information we had received about the service since the last inspection. We sought feedback from the local authority. 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 one person who used the service and three relatives about their experience of the care provided. We spoke with five members of staff including the home manager, care staff and a kitchen staff member. We observed staff providing care to people.

We reviewed a range of records. This included three people's care records and four medicines administration records. We looked at four staff files in relation to recruitment and staff supervision.

A variety of records relating to the management of the service, were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at the service's statement of purpose, cleaning schedules, COVID-19 policy and fire records. We made calls to relatives on 15 and 18 October 2021.

We shared our concerns with the Local Authority and requested a fire officer attend to review the safety of the fire systems and processes at the service.

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had not operated effective safeguarding systems and processes to protect people from abuse and improper treatment. This was a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● After our last inspection in February 2021, the registered manager submitted an action plan telling us what improvements they would make to become compliant with the regulation by 31 May 2021. At this inspection we found they had failed to meet their action plan. There were no audits, safeguarding records or staff meetings to discuss safeguarding, or safeguarding training recorded. One staff member said, "I have not had safeguarding training for a while, we need it regularly."
● Staff knew how to whistle-blow and raise concerns if they felt they were not being listened to or their concerns acted upon. However, some staff told us they did not have confidence in the service's whistle-blowing procedure as when they had raised concerns no action had been taken.
● Staff recorded people's distressed behaviours in their care records. These records had not been audited to identify themes, trends and causes of distressed behaviours. There were no care plans or risk assessments for one person with distressed behaviours. This meant staff did not have adequate guidance to know how to respond if they were distressed. Furthermore, they did not have dementia training.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to protect people from abuse and improper treatment. This was a breach of regulation 13 (1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● There were no screening checks in place for visitors to Rearsby Home Limited to determine whether they had symptoms of COVID-19, had been a recent contact of someone with COVID-19 or undertaken a test to show they did not have COVID-19. We observed one professional visitor enter the service without evidencing they had undertaken a 'lateral flow' test. One relative said, "The manager didn't know about the lateral tests initially and kept changing their mind. In the last few days [after the inspection] they are now doing the test, you let them [staff] know and they record it. They should have done that from day one."

● There was no record of staff undertaking lateral flow tests. The homes testing policy and procedure had not been updated to reflect government guidance to undertake lateral flow tests twice weekly. There was a risk there would be a delay in identifying COVID-19.
● People were not always safely admitted to the service. One person had been admitted from another care home. There was no record of a COVID-19 test being taken before their admission. They did not isolate in their room and an enhanced regime of COVID-19 including daily lateral flow tests had not been undertaken. Furthermore, records evidenced they had spent time in the lounge area, whereby we observed there were no social distancing arrangements in place.
● Staff did not always have prompt access to the Personal Protective Equipment (PPE) they required. PPE was only available on the ground floor. There was no hand sanitiser or PPE on the upper floor of the service. During the inspection we observed occasions whereby staff's face masks were placed below their chin or had slipped below their noses.
● There was no enhanced or more frequent cleaning to include high touch areas such as door handles and light switches. This was identified as an area for improvement following our last inspection. However, no improvements had been made. There was no evidence the room used for visiting was cleaned prior to and after visits and no evidence of rooms being deep cleaned.
● The infection prevention and control failings identified during this inspection further increased the risk of transmission of COVID-19. This was further increased as there had been an outbreak of COVID-19 at the service in September 2021.

Assessing risk, safety monitoring and management
● Following our last inspection, the service told us fire risk assessments were carried out on an annual basis. However, we found a fire risk assessment had not been undertaken. Personal Emergency Evacuation Plans (PEEPs) were available within people's individual care files. However, there was no current record of people's bedroom numbers. This meant in the event of a fire, emergency services would not be able to access correct information to facilitate a safe evacuation.
● Risks to people had not always been assessed. For example, one person was at high risk of falling because they had a health condition that needed monitoring and distressed behaviours. No risk assessments or care plans had been implemented for them. This meant staff did not have the guidance they needed to support the person safely, and risks to the person had not been identified and reduced.
● There were no COVID-19 risk assessments in place for people or staff. This meant people's individual risks had not been considered and action had not been taken to reduce these. One person was accessing the community and public transport. The risks this posed to the person and other people at Rearsby Home Limited had not been considered or reduced. This put people at an increased risk of being exposed to COVID-19.
● There were areas of the service that were unsecured or restricted. This included the front door, clinic room, a bedroom used for storage and the stairwells. People were able to access these areas without staff knowledge. This put them at risk of harm and falls from height.

Using medicines safely
● Staff medicines training was overdue. We observed a staff member administering medicines without checking the medicines inside the boxes were correct. This put people at risk of receiving the wrong medicines. We also observed a staff member administering medicines without wearing gloves, washing their hands or using hand sanitiser which increased the risk of cross infection.
● One person did not have a protocol in place to instruct staff when to give them medicines for distressed behaviours. They had been given this medicine daily for seven days in a row. There was a risk this medicine would be overused, or that it would be given unnecessarily.
● Medicines administration record (MAR) audits had not been completed since July 2021. This meant

medicines errors may not have been identified and the opportunity to identify areas for improvement had been missed.

Learning lessons when things go wrong

● Records showed staff documented accidents and incidents when they occurred. However, there no audits of accidents, incidents and falls. This meant opportunities to identify themes, trends and lessons learned were missed.

There was a lack of robust systems and processes to demonstrate safety was effectively monitored and managed. This placed people at significant risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They sent us evidence one person's care plans and risk assessments had been completed. They sent us an action plan detailing how they would make the improvements and told us these would be implemented by a new management team.

Staffing and recruitment

● At the last inspection the registered manager told us recruitment processes and procedures were being improved. However, we found improvements had not been made.

● We looked at four staff files. There were no start dates recorded in three; no interview records in all four and no references in one. One staff member had commenced employment without a Disclosure and Barring Service (DBS) criminal record check. Two staff files stated a DBS had been undertaken, but the outcome had not been recorded. An audit undertaken in June 2021 identified nine staff had not had a DBS check, but there had been no further audit undertaken.

There was no evidence people had been harmed. However, there was a lack of robust systems and processes to demonstrate safe recruitment was effectively managed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not use a dependency tool to assess people's needs and plan staffing. One person's care record evidenced they experienced distress daily and they required frequent staff support. This person's needs had not been assessed to inform staffing levels.

● We observed care staff to be busy meeting people's needs during inspection. They had little time to spend with people. Staff told us there were not enough care or kitchen staff. One staff member said, "We need more staff as we are not spending time with people one to one, we are spending more time doing tasks. It's not fair on people." We observed one staff member stay at least two hours after their shift had ended to complete care records. A relative said, "Staff always seem a bit rushed off their feet."

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
At our last inspection the provider did not have systems in place to ensure staff received appropriate support, supervision and training, necessary for them to carry out their role and responsibilities. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- After our last inspection the service submitted an action plan telling us the improvements they would make to comply with the regulation. They told us supervision records would be audited, a training matrix including supervision was in place, an open-door policy had been implemented, dementia, continence care and equality and diversity training would be provided, and staff surveys annual appraisals and supervisions would be implemented. However, we found this action plan had not been met.
- People did not always receive care and support from competent and skilled staff. The staff training matrix did not include training on safeguarding, dementia, medicines administration, fire, COVID-19, and positive behaviour support. Furthermore, the training matrix evidenced all staff training was out of date. The manager advised some staff had undertaken some training. However, there were no records available to support this. This meant not all staff had up to date knowledge to enable them to carry out their duties effectively which put people at risk.
- There was no evidence of an induction being undertaken for some staff including the home manager. One staff member said, "Some staff that have been employed still need moving and handling training as they don't know what they are doing."
- Staff told us they had received a recent supervision. However, prior to this they had not received a supervision for some time. This meant their learning and development needs had not been identified and responded to and they did not receive feedback relating to their practice.

Systems were not in place to ensure people were supported by competent and skilled staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They sent us an action plan detailing how they would make the improvements and told us these would be implemented by a new management team. They sent us an 'up

to date' training matrix, which showed some staff training had been undertaken.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● The DoLS matrix was out of date; we could not determine whether DoLS had been appropriately applied for. We found an urgent authorisation had not been requested for one person for eight days after they moved to the service. This meant they were unlawfully deprived of their liberty for this period.
● The service had not identified whether people had a Lasting Power of Attorney (LPA). LPA gives representatives the legal authority to make decisions on a person's behalf.
● Mental capacity assessments and best interest decisions were not always fully completed and did not always evidence people, their relatives or LPA had been consulted. There was an absence of a mental capacity assessment or best interest decision for one person that did not have capacity to make decisions about their care or treatment.

We found no evidence that people had been harmed however, there was a risk people's rights would not be upheld. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They told us all required DoLS authorisations were either in place or had been applied for and sent an 'up to date' matrix.

● We observed staff offering people choices throughout our inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's physical, social and wellbeing needs had not always been holistically assessed before receiving care from the service. We found admissions assessments had not always been fully completed.
● Care and support was not always delivered in line with legislation and evidence-based guidance to achieve effective outcomes. Government guidance relating to the COVID-19 pandemic had not been shared with staff and was not always followed.

Adapting service, design, decoration to meet people's needs
● Some people living at the service lived with dementia. However, we found that other than pictures being placed on doors, the physical environment was impersonal, and consideration had not been given to create a safe and supportive environment for people living with dementia.

● Some people's bedrooms had been redecorated. There was, no evidence people had been consulted to establish their preference for décor.
● The room used for relative visits was plainly decorated, minimal and used to store lifting equipment. One relative said, "I wish they had something more welcoming in the TV room, especially now in the winter months."
● There was not enough storage for equipment. The base of a stairwell had been used to store equipment that was no longer in use, and a bedroom, accessible to people was full of boxes, soft furnishings and equipment. This placed people at risk of harm.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Records showed professionals had not always been contacted when a person's health needs had changed. For example, one person was at risk of falling from their chair. A referral had not been made to appropriate professionals to review the suitability of equipment in use. One relative told us there had been a delay in contacting healthcare professionals for a health need. However, two relatives provided positive feedback that professionals were always contacted promptly for health concerns.

Supporting people to eat and drink enough to maintain a balanced diet
● People's weight was recorded monthly. However, weight charts had not been audited since July 2021. This meant the management team had missed an opportunity to identify themes and trends relating to people's weight loss.
● Peoples likes, dislikes, dietary and preferences were detailed in their care plans. Staff knew people's needs well, offered them choices and encouraged them eat a balanced and varied diet. The kitchen staff gave examples of meals they had prepared to meet people's cultural, ethical and religious needs.
● We received positive feedback about the food available at Rearsby Home Limited.

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 now 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; Working in partnership with others

At our last inspection the provider did not have effective quality assurance systems in place to effectively monitor the quality and safety of the service. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● After our last inspection in February 2021 the service submitted an action plan telling us the improvements they would make to become compliant with the regulation by 22 April 2021. However, this action plan had not been met. Furthermore, the services own 'CQC action plan' dated 17 March 2021 was found to have no actions recorded. Recommendations from the infection prevention team in April 2021 had not been implemented.
● There was a registered manager employed at the service. However, they were only at the service one day a week. The acting manager appointed did not have any prior experience of managing a care home and had not had an induction. This meant they were unclear of the expectations of the provider and had a limited understanding of the regulatory requirements.
● There were widespread failings relating to the leadership and governance of the service. The registered manager and provider failed to ensure adequate quality assurance systems were in place to monitor the quality and safety of the service. There was an absence of audits, including, but not limited to accidents and incidents, safeguarding, falls, equipment, complaints, pressure sores and the environment. The registered manager and provider had failed to identify and/or address the concerns found prior to and during this inspection.
● Due to the governance failings, the service was unable to confirm to us during inspection how many people resided at the service, what training staff had received and what DoLS authorisations had been applied for. The complaints information displayed in the service detailed contact details of the previous provider. Prior to the inspection both CQC and the Local Authority had experienced difficulties obtaining information from the service.
● Staff did not receive adequate support from the management team to enable them to undertake their role effectively or to identify areas for development and improvement.
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 provider's policy set out the services responsibilities in relation to duty of candour. However, we received feedback prior to our inspection this was not always followed. One relative advised an apology had not been offered following an accident whereby the person had sustained an injury.

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

● Relatives and staff had not had the opportunity to provide feedback about the care delivery. Relatives had not always been consulted when people's care plans had been reviewed.

● There had been no meetings with people to seek their feedback on their experience of receiving care and to drive improvements.

There was an absence of systems and processes in place to demonstrate safety was effectively monitored and managed. This placed people at significant risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They sent us an action plan detailing how they would make the improvements and told us these would be implemented by a new management team.

● CQC's rating of performance was displayed at the location.

● Some staff told us they wanted the service to improve. One staff member said, "We want to improve the home and make it a good home."

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

● People had limited opportunities to engage in activities of interest. This had been further impacted by the COVID-19 pandemic. One relative said, "When you look on the board, there are no activities. There is not a lot for [Name] to do, that then makes us sad as all they are doing is sitting in their room." Staff told us they did not have time to spend with people and we observed care delivery was mostly task orientated.

● Staff we spoke with were committed to their roles and willingly worked additional hours to ensure people received care from familiar staff. Staff spoke positively about the people they cared for and we observed kind and caring interactions with people during our inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a risk people's rights would not be upheld.

The enforcement action we took:

Imposition of conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of robust systems and processes to demonstrate safety was effectively managed. This placed people at significant risk of harm.

The enforcement action we took:

Imposition of conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were either not in place or robust enough to protect people from abuse and improper treatment

The enforcement action we took:

Imposition of conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was an absence of systems and processes in place to demonstrate safety was effectively monitored and managed. This placed people at significant risk of harm.

The enforcement action we took:

Imposition of conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was a lack of robust systems and processes to demonstrate safe recruitment was effectively managed.

The enforcement action we took:

Imposition of conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were not in place to ensure people were supported by competent and skilled staff.

The enforcement action we took:

Imposition of conditions on the providers registration.