Georgetown Care Limited

The Haven

Inspection report

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16 February 2022
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25 February 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Haven is a residential care home providing accommodation and personal care for up to 12 older people in one adapted building. There were seven people using the service at the time of the inspection, some of whom were living with dementia.

People's experience of using this service and what we found
The service had been without hot water since 15 January 2022, a period of five weeks, before it was restored. This meant people were unable to have a bath or shower, which increased the risk of skin damage and lessened the opportunity for relaxation from distressed behaviours. The lack of hot water compromised good infection control practice, such as effective handwashing. There was an increased risk of scalding, as staff were using a domestic kettle and then carrying the water to people's handwash basins in their bedrooms.

Less visible areas of the home were not clean and additional cleaning to work safely during COVID-19 was not evidenced. This included the cleaning of high levels of contact touch points. Night staff completed some cleaning, but there was only one housekeeper who worked for five hours each day in the week. Other aspects of the environment did not enable effective cleaning. There was chipped paintwork on door frames, skirting boards and the tops of radiator covers.

Staffing arrangements at the service was fragile. Some staff had left and recruitment was a challenge. There was a high reliance on agency staff and permanent staff were working excessive amounts to help cover. The manager completed some shifts, which took them away from their management responsibilities. Records did not evidence robust recruitment procedures were being followed. There was a lack of information about the process or the applicant's attributes, to enable a successful appointment.

Some aspects of the environment did not ensure safety. This included an open door to the sluice, which gave access to hazardous substances, and two fire doors to people's bedrooms that were propped open. Other aspects of the environment needed maintenance. This included a radiator in a person's bedroom which did not work, another radiator that had a broken cover and a tap on a hand washbasin in a bathroom which had been turned off. At the time of the inspection, there was no date for these items to be fixed.

Systems were not sufficiently robust to ensure people's safety. Accidents, incidents and injuries people had sustained had not been properly investigated or reported. Records were incomplete or insufficiently detailed to evidence what had happened and the injuries sustained. There was no information about what action had been taken to minimise a re-occurrence or any learning moving forward.

Risk management was not effective. Risk assessments were not regularly reviewed, or updated following an accident or injury. Not all assessments were accurate, which did not ensure control measures in place were sufficient. Care records did not clearly demonstrate the assistance people received. This did not enable an

accurate review of people's needs or the care they received.

There had been some improvement to the way people's medicines were managed. However further improvements were needed.

The service has a poor history of compliance, with a lack of oversight from the provider. There has been a lack of auditing, and shortfalls in the service have not been identified and addressed in a timely manner. There had not been any urgency to rectify problems such as restoring the hot water and previously, repairing the broken dishwasher and passenger lift. These shortfalls and the injuries sustained to people following an accident or injury were not reported to CQC or the local authority as required. People, their relatives or advocates were also not appropriately informed.

As a result of our inspection in November 2021 and December 2021, we issued two warning notices to ensure improvements were made to the service. One warning notice was in respect of regulation 15, which related to the premises and equipment. The second notice was in respect of regulation 17, good governance. We returned to the service in January 2022 to check compliance with the notice related to premises and equipment. We found this had not been met in full, and shortfalls remained. The compliance date for meeting the second notice is not yet due. However, we can inspect if we have new concerns about people's health or safety.

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 25 February 2022) and there were breaches of regulation. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to a high level of bruising people had sustained and there not being any hot water in the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

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

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

You can 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 The Haven on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to the systems to protect people from the risk of abuse, risk management, infection prevention and control, and good governance including not reporting notifiable events.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Haven

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
This inspection was carried out by three inspectors, one of whom was a member of the CQC medicines team.

Service and service type
The Haven is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Haven is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 15 February and ended on 03 March 2022. We visited the service on 16, 17, 21, 23 and 25 February 2022.

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 (PIR) prior

to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we observed interactions between staff and people who used the service. We spoke with two relatives, five member of staff and the manager, and three visiting professionals. We looked at five care plans and other associated care records and toured the building. We checked people's medicines records and looked at arrangements for administering, storing and managing medicines.

After the inspection
We looked at information the manager sent us, which was not available when we were at the service. This included staff training and infection prevention and control audits.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- We are not assured systems were sufficiently robust to protect people from the risk of abuse.
- Prior to the inspection, we received some information of concern regarding injuries and bruising people had sustained. This included one person who had significant bruising to their fingers, another who had sustained an injury to their leg and another person who had allegedly fallen down some steps resulting in a head injury and significant pain. Another person had an injury, which appeared to be consistent with finger-print bruising. The manager nor the staff we spoke with were able to give a clear account of how any of these injuries were sustained. When we looked at records relating to these injuries, we found they were inconsistently completed and lacked detail. The information did not give an accurate account of the circumstances leading up to the injury, how the person was found, or a clear description of the injuries such as size, colour or location of the bruising. Some incident forms were not dated, or clearly specified what had happened or who was involved. The records did not show any action taken to mitigate risk or prevent a re-occurrence to ensure safety.
- Care records did not demonstrate, and the manager and staff were unable to confirm in all cases that appropriate medical attention was gained as a result of the injuries sustained. In one case the manager and the records confirmed that advice was sought via 111, and as a result the GP had visited. However, details of the GP and the outcome of their visit were not documented. This lack of documentation did not allow a review of the treatment to be completed to ensure it was being given as directed, or if it was effective.
- Care plans and risk assessments were not updated or reviewed as a result of the injuries sustained. The manager confirmed no formal investigation was undertaken or documented as a result of any of the injuries. This did not mitigate the risk of further occurrence or to keep people safe.
- Staff told us they would inform the manager if they had concerns about a person's safety. However, the manager told us they were not always informed of any injuries people had sustained. They confirmed no safeguarding referrals to the local authority had been made, as a result of any of the injuries people had sustained. Similarly, there were records which showed a person had hit another, but this also, had not been reported to the local authority. This did not ensure the required systems were being followed to protect people from the risk of harm.

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- We are not assured risks to people's safety were adequately identified, monitored or addressed to minimise harm.
- At our inspection on 14 January 2022, we identified the water supply to a handwash basin in the shower

room was very hot, and off the scale of the thermometer. The excessive temperature posed a risk of scalding to people living at the home.

● The manager told us and the provider confirmed, a boiler engineer was called to address the unsafe temperature. They visited on 15 January 2022, and deemed the hot water cylinder unsafe. To minimise the risk of the tank exploding, they lessened the temperature of the water within. However, this in turn affected the temperature of the water throughout the home. Since the engineer's visit on 15 January 2022, a period of over 5 weeks, the manager and staff confirmed the home did not have any hot water. This meant no one was able to have a bath or shower. This posed a risk of harm to people, particularly as some experienced problems with their continence. Staff confirmed people were supported to wash, but a lack of effective personal hygiene, increased the risk of skin damage.

● Some people were living with a dementia and sometimes demonstrated anxious or distressed behaviours. The manager and staff told us that having a bath helped some people relax and increased wellbeing. Due to not having any hot water since 15 January 2022, assisting people with a bath was not possible. Staff told us they had missed the opportunity to support people in this way. One relative told us their family member relaxed when having a bath, but also maintaining a clean, well presented appearance was important to them.

● Staff told us, we observed, and the manager and provider confirmed that to provide hot water to people in their bedrooms, staff boiled a kettle in the kitchen. They then took jugs of hot water to the person's handwash basin in their bedroom. Walking around the home with hot water posed a risk of scalding, particularly with the jug staff were using. There was a risk of significant harm if staff had tripped or fallen.

● Assessments of other risks people faced had not always been completed accurately, regularly reviewed or updated following an incident or accident. For example, one person had been assessed as being at high risk of skin damage, but their level of continence had been wrongly calculated. This error meant there was a risk that measures to support the person may not have been sufficient to ensure healthy skin. There had been a period of six months between assessments. Another person had been prescribed a soft diet and thickening agent in their drinks to minimise the risk of aspiration. There was no care plan in place in relation to the risk of choking, including how the person should be positioned to ensure safety.

● There were risks within the environment, which did not ensure people's safety. This included the sluice room, which was left unlocked with the door open. This gave unsecured access to washing powder, descaler, and washing machine cleaner. There were also two bedroom doors, which were fire doors, that were propped open, one with an ornament and another with a black bag. This did not enable the doors to safely close, in the event of a fire.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

Preventing and controlling infection

● Infection prevention and control was not effectively managed to ensure people's safety.

● The provider told us after delivering personal care, staff removed their gloves and used alcohol gel. They then went into a bathroom where there was a supply of hot water to wash their hands. Alcohol gel, however, is not effective against the spread of Clostridium difficile spores and Norovirus (bacteria found in faecal matter), which may have been on staff's hands.

● The manager and staff told us additional and frequent cleaning related to working safely in COVID-19, such as high levels of contact touch points was undertaken on an ad hoc basis when time was available. The housekeeper told us they completed such cleaning, as they went around the home, but were often on a tight schedule so not all areas were addressed each day. There was not a formal routine, and cleaning schedules did not demonstrate when such cleaning was undertaken. The daily cleaning records staff signed to evidence the cleaning they completed, had not been signed since 31 December 2021. During the inspection,

one person had a visitor, but staff did not clean the area they had used when they left.
● The lack of effective hand hygiene and cleaning of high touch areas left people at risk from the spread of infection. In addition, due to the issues identified with the hot water supply, we were not assured that the infection prevention and control procedures were effective.
● Government guidance in relation to COVID-19 was not always being followed. For example, staff who had tested positive for COVID-19 in the last 90 days, were not carrying out LFT testing. This did not ensure effective detection of the virus, which increased the risk of transmission.
● Less visible areas of the home were not clean. For example, cobwebs at a window in a person's room, the conservatory and sluice room, and debris on an electric fan and heater.
● Some aspects of the building such as door frames, skirting boards and the top of radiator covers had chipped paintwork. This meant these areas could not be kept properly clean. Some carpets in the building were stained. There were no records to show how the many ornaments, books and games were cleaned regularly to prevent cross contamination.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

● Staff and the manager told us there were stocks of personal protective equipment (PPE) available to use as required. Staff were using disposable masks correctly, and said full PPE had been worn during the outbreak of COVID-19. This included masks, gloves, aprons and visors, to ensure safety.
● Staff had completed training in infection prevention and control. The manager told us various discussions had been held with staff, to ensure they applied their learning in practice. However, one member of staff had painted nails and bracelets on, which was not in accordance with infection control best practise.

Staffing and recruitment
● A robust recruitment procedure was not being followed. Records did not show clear information had been gained about the applicant's past history or performance. For example a reference request for an applicant was missing and could not be found. One reference was not from a present employer, which did not give an up to date view of the applicant's ability. There was no clear audit trail regarding the information to verify it, and no details of any interviews taking place.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed

● At the time of the inspection, there were staff vacancies. A high number of staff had left the service, and recruitment of new staff was proving a challenge.
● The team was made up of six permanent care staff to cover both day and night shifts, and one housekeeper. There was a high reliance on agency staff. The housekeeper worked 5 hours per day and was not employed to work at the weekend. At these times, care staff were responsible for completing the cleaning.
● Permanent staff were covering additional shifts. One member of staff said they were working 50 to 60 hours a week to help. The manager was completing care shifts which could not be covered by permanent staff or agency. This took them away from their management responsibilities.
● The same four agency staff were booked on a consistent weekly basis, to ensure people received consistency with their support. Two of the agency staff were members of the manager's family.
● The manager told us they had an excellent, committed, caring staff team. They said they were developing their skills, and always picked up extra shifts to help as needed. The manager said staff had worked hard during the pandemic and were amazing at the time of the outbreak.

● Staff spent time doing a range of one to one activities with people in the lounge. They said they enjoyed having time to do this, and valued the relaxed routines in the home. They said people were enabled to get up when they wanted to, and there was no rushing to get from one person to another.

Using medicines safely

● Improvements have been made to the way people's medicines were managed since our previous inspection. An improvement plan and a new audit tool had also been introduced. However, we found some areas where further improvement was needed.

● Medicines records had improved, and systems had been put in place to identify and address any errors in recording. Most regular medicines appeared to be given as prescribed. However, there were two missed signatures for the previous evening's medicines. The manager told us these would be investigated, and action taken as necessary.

● Handwritten entries staff had made on medicines record charts were not always signed and checked by a second member of staff. This is not in line with the National Institute for Health and Care Excellence (NICE) guidance or with the home's policy.

● The medicines keys had recently been mislaid. The manager told us they would put more robust systems in place for handing over keys at each shift change, and to make sure medicines were stored securely at all times.

● Staff had separate charts to record the application of topical creams and other external items. These contained body maps to show staff where to apply the product. However, full directions such as how the cream was to be applied and the frequency, was not always recorded. The charts were generally well completed, although there were gaps in some. This omission of recording did not clearly show whether the products had always been applied when needed.

● There were clear and detailed person-centred care plans for when medicines, prescribed to be taken 'as required', might be needed. One person tended to become anxious, and the signs they displayed when this happened were clearly detailed in their care plan. The guidance for staff on how to provide reassurance and prevent any escalation was very detailed. This was of benefit to the person and avoided unnecessary use of medicine.

● We observed two people's medicine being given and saw they were administered in a safe way. We discussed timings of rounds, as some people liked to get up and have their morning medicines later. Staff were aware when this happened and gave later doses with a suitable gap when necessary. However, the manager said they would introduce a more robust system for recording when this happened.

● Staff had received updated training in safe administration and had checks to make sure they gave medicines safely. A new pharmacy supplier was being used, and they were assisting with further staff training and medicine storage arrangements.

● There were suitable arrangements for cold storage of medicines if required and for those medicines needing extra security.

Visiting in care homes

The manager told us people were able to receive visitors, in line with government guidance that was current at the time. They said visiting was important to people, and had a positive effect on wellbeing. Visitors were asked to call the home to arrange their visit. The conservatory was generally used for visiting although visits in people's rooms or the lounge were permitted. At one point in the pandemic, garden visits were allowed, rather than visiting inside.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- We are not assured that the provider and manager understood their duty of care to the people they supported or their legal responsibilities.
- During the inspection, the provider confirmed to us that they had secured an engineer to carry out remedial works to the hot water system. However, there was a significant delay in securing this, as it was first identified on 15 January 2022. The engineer did not start work until the 22 February 2022.
- At our inspection in November 2021 we found that the provider had not informed us of events at the service in line with the regulations.
- The provider had not submitted notifications in line with the regulation as a result of the issues with the hot water, or the injuries people had sustained as described in the safe domain of this report.

This is a continued breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

- The service has a poor history of compliance. In November 2021 we visited the service and found that quality assurance systems were not in place. We met with the provider to discuss our concerns. The provider gave assurances they were aware of their responsibilities as a provider. We issued a warning notice following this inspection. In December 2021 we inspected the service again. The service was experiencing a significant outbreak of COVID-19. At this time the provider had cut staffing numbers and a person in an upstairs bedroom, was unable to go down to the lounge as the lift was broken. The dishwasher was also broken, two of the bathrooms were out of use and the laundry room was in a poor state of repair. It was only after we had visited the service and met with the provider, that action was taken to address these areas. At this inspection, issues with the hot water system were identified.
- Systems to assess monitor and mitigate risks to people were not effective. The service did not keep accurate and complete records. For example, some audits, incident records and a reference for a new member of staff were difficult to locate or were explained as being on other laptops which could not be accessed.
- The manager confirmed documented investigations had been not been completed as a result of any accident, injury or fall. There had been a summary of how many falls had occurred but no clear quality assurance system to identify any patterns or trends as a result of accidents or incidents. This did not keep people safe, mitigate on going risks or promote any learning from events.
- Some shortfalls with the environment had not been identified or addressed. For example, one radiator in a

person's bedroom and the shower was not working, a radiator cover was broken, and the hot water tap in a bathroom had no water coming from it. A catch for the oven door had been purchased, but no one was able to fit it. There remained an empty hand sanitiser unit outside by the front door. The manager told us they were waiting confirmation from the provider but expected all jobs to be completed after the hot water had been restored.

● Care plans had a date which showed they had been reviewed. However, this was not in response to any event such as an accident or incident. Not updating care plans at this time, did not ensure adequate control measures were in place, or that care interventions were effective. The care plan reviews or quality auditing systems had not identified this. They had also not identified some risk assessments were inaccurate. This did not ensure that risks were mitigated or any learning was identified.

● The manager told us following the warning notice which had been served at the last inspection, the provider visited the home more often. They said they looked at records and talked to people and the staff on duty. However, they did not leave any record of their visit or any recommendations or action plans.

This is a continued breach of regulation 17 of the Care Quality Commission (Registration) Regulations 2009: Good governance

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 confirmed that other agencies such as the local authority who commissioned care or the local safeguarding team, had not been informed about the lack of hot water at the service or the injuries people had sustained. This did not allow other statutory agencies to ensure appropriate action had been taken to keep people safe and to ensure that care was provided in line with their assessed needs.

● Communication to people, their friends, family and advocates was not effective in order that people could make informed decisions about their care and treatment. For example, the local authority placed the service on "red alert" on the 9 December 2021 due to concerns at the service. Relatives we spoke with confirmed they were unaware of the red alert status. They were also not aware of the issues with the hot water system, which had resulted in their relatives not being able to have a bath or shower for the last five weeks. The manager told us this was an oversight on their behalf and they had not realised what being on "red alert" meant. They said they had told a few relatives about the hot water, but this was not the experience of those spoken to.

● Whilst we saw some good interactions between staff and people using the service, we are not assured there was a positive culture at the home. Staff turnover had been high over recent months and staff had left at short notice, with some not working their notice period. The manager confirmed that neither they nor the provider completed formal exit interviews with staff. This did not enable them to learn about any issues staff may have been experiencing or to use staff's views to improve the quality of care people received.

● The high turnover of staff had left the home being reliant on high numbers of agency staff. Whilst the same agency staff were used, the lack of permanent staff had impacted on the team. Staff were repeatedly working additional shifts. One staff member undertook the cooking in the morning and then worked a care shift in the afternoon and evening. The manager also completed care shifts at short notice, which took them away from their management responsibilities. Working long hours does not maintain staff's well-being or ensure they carry out their duties well.

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

The service did not have a registered manager. The manager had been in post for approximately six months

and had not submitted an application to register with CQC. The provider is required to have a registered manager at the service as a condition of their registration.

Working in partnership with others

- The manager said as they were not registered, the opportunities available to them were more limited. This included not being part of manager forums, to share experiences and develop learning.
- The service did not have a list of known contractors to call upon if needed. The manager was required to source any contractors who were needed and gain quotes for their work. These were then passed to the provider to authorise. The manager did not have a budget to work within. All financial interactions were authorised by the provider.
- The manager told us they had good relationships with local surgeries, the GPs and community nurses. They said they visited as required when called, and gave advice and agreed treatment plans.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not sufficiently robust to protect people from the risk of abuse or harm. Regulation 13(1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed A robust recruitment procedure was not being followed, which did not ensure prospective staff were of good character and suitable for their role. Regulation 19(2)(3).