ABC Care Home Ltd

Burnside Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Burnside Court is a 'care home' that provides care and support for a maximum of 26 older people, some of whom may be living with a dementia and/or physical frailty. At the time of the inspection 24 people were living at the service.

People's experience of using this service and what we found
Although people who were able to share their views with us told us they were happy living at Burnside Court, and relatives we spoke with did not raise any concerns about the quality of care provided.

We found the service was not always operating in accordance with the regulations and best practice guidance. This meant people were at risk of not receiving care and support that promoted their wellbeing and protected them from harm.

Key pieces of information relating to people's care and support needs were not always being recorded or followed up.

People were not always protected from the risk of avoidable harm. We found where some risks had been identified, enough action had not always been taken to mitigate those risks and keep people safe.

People were not always protected from the risk and spread of infection.

People were not always protected by safe recruitment procedures.

People were not supported to have maximum choice and control of their lives and staff were not supporting people in the least restrictive way possible and in their best interests.

Systems and processes to monitor the service were not undertaken robustly. This meant they were not always effective; did not drive improvement; did not identify the issues we found at this inspection and could not be relied upon as a source to measure quality and risk.

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 27th March 2020). Following that inspection, the provider was asked to complete an action plan to show what they would do and by when to improve. This was not received by the Commission .

At this inspection we found not enough improvement had been made and the provider remained in breach of regulations. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This inspection was part prompted by a review of the information we held about this service. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe, Effective and Well-led which contain those requirements.

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.
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 remains requires improvement based on the findings of this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Burnside Court 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 safe care and treatment, infection prevention and control, need for consent, recruitment and governance at this inspection. We have also made recommendations in relation to management of people's medicines and staff induction processes. Please see the actions we have told the provider to take at the end of this report.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Burnside Court

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 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 team was made up of one inspector and an Expert by Experience who had consent to phone and gain feedback on the care provided by the service from people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Burnside Court 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. 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
The first day of the inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information we held about the service, including notifications we had received. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales. We also used information gathered as part of monitoring activity that took place on 11

February 2022 to help plan the inspection and inform our judgements.

We sought feedback from the local authority and used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.
We used this information to plan the inspection and took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spent time with and spoke with six people living at the service, 12 relatives, five staff members and the registered manager. Some people living at the service were unable to talk with us. We used the principles of the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. To help us assess and understand how people's care needs were being met we reviewed four people's care records. We also reviewed a number of records relating to the running of the service. These included staff recruitment and training records, medicine records and records associated with the provider's quality assurance systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at care plans, training data and quality assurance records and spoke with a representative from Torbay Council.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• People were not always protected from the risk of avoidable harm as risks to people's health, safety and well-being had not always been identified, effectively managed or mitigated.
• Some people had been assessed as needing pressure relieving equipment such as pressure mattresses and cushions to reduce skin damage. There was no guidance in people's care plans or risk assessments to instruct staff on what pressure mattresses should be set at and daily mattress checks were not being completed by staff regularly.
• We found three people's pressure mattresses were not set correctly for the person's weight which meant they could be at risk of unnecessary skin damage.
• One person had been identified at high risk of malnutrition following recent weight loss. Staff told us they monitored and recorded their food and fluid intake as part of their daily observations. However, we found this person's food and fluid intake was not always recorded in enough detail, monitored or analysed. There was no nutritional care plan and a referral had not been made to the person's GP or dietician. When we returned to the service for day two of the inspection, we found a referral had been made.
• People were not always protected from risks associated with their environment as routine environmental checks were not regularly taking place. For example, water temperature; window restriction and fire safety checks.
• Where some risks had been identified the registered manager could not demonstrate that action had been taken to mitigate those risks to keep people safe. For example, records showed water temperatures exceeding 43 degrees centigrade were being recorded but no action was taken. This meant people had been placed at an increased risk of avoidable harm (scalding).
• During a tour of the service we found two Velux windows on the fourth floor were not restricted, this placed people at an increased risk of falls from height. We brought this to the attention of the registered manager took immediate action to ensure people's safety.
• We reviewed the service's fire safety precautions. Fire safety records showed that fire safety checks had stopped being completed in November 2021. We discussed what we found with the registered manager who told us environmental and fire safety checks had stopped when the previous maintenance person had left the service. A new maintenance person had started at the service on the day of our inspection.
• Records showed accidents and incidents were being recorded. However, this information was not being analysed or reviewed. This meant the provider could not be assured that lessons had been learnt or enough action had been taken to keep people, staff and others safe from harm.

The failure to effectively manage and mitigate risks placed people at an increased risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People were not always protected by safe recruitment procedures.
• We looked at the recruitment information for two staff members. Whilst some recruitment checks had been carried out, others had not. For example, records for both staff members did not contain a complete work history and the registered manager had failed to follow up on information contained within one person's previous employment reference.
• This meant the registered manager was unable to demonstrate they had followed a thorough recruitment process in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to establish and operate safe and effective recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were supported by a regular team of care staff who knew them and their needs well. One person said, "They're [meaning care staff] all lovely and they look after me very well."
• Relatives told us people were well supported and staff assisted them in an unhurried manner and in the way they liked. One relative said, "There always seems to be enough staff and dad never seems to wait for his care. Staff seem to check on him regularly." Another said, "I would say so. We hear people's call bells when we visit, but not continual and never for very long. Staff seem to attend to people's needs promptly."

Using medicines safely
• Some people were prescribed medicines to be given when required. Protocols to help staff to decide when to give these medicines did not always contain enough information to ensure the medicines could be given safely and consistently.
• Staff signed medicines administration records (MARs) following medicines administration. For some medicines the time of administration or the gap between doses was important to make sure they were safe and effective. Staff did not always record the time of administration, so could not be sure of a safe gap between doses. For example, in relation to pain relief medicines.
• There were systems in place to audit medication practices. However, we found audits had not been completed since November 2021.

We recommend the provider seeks advice and support from a reputable source on ensuring that people's medicines are managed safely and in accordance with current best practice guidelines.

• People were given time and encouragement to take their medicines at their own pace and staff always sought people's consent.
• Medicines were stored securely with access restricted to authorised staff.
• Medicines were ordered and disposed of safely and securely.
• Staff were trained to support people to take their medicines safely and told us they had their competency regularly assessed.

Preventing and controlling infection
• We were not assured that staff were using PPE effectively and safely. For example, on the first day of the inspection we observed one member of staff remove their mask and place it in their pocket whilst on their break. They did not wash or sanitise their hands before putting the mask back on and returning into the property. Another member of staff removed their mask while speaking with us. Senior staff did not challenge this poor practice.

The failure to effectively manage risks relating to infection control and the transmission of COVID-19 is a

breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

Relatives we spoke with did not raise any concerns about the wearing of PPE or the cleanliness of the service. One relative said, "The service is always 'spotless' and everyone wears PPE".

The provider was facilitating visits for people living in the home in accordance with the current guidance. Relatives we spoke with told us they had been able to visit their relations regularly. One relative said, "They are fine about visiting. I book an appointment in advance, as they do not want too many people visiting on the same day." Another said, "I am aware of the visiting arrangements and these seem to work fine."

Systems and processes to safeguard people from the risk of abuse
• People who were able to share their views with us, told us they felt safe and were happy living at Burnside Court. One person said, "I do feel safe here, much safer than at home." Another said, "I'm happy here." Relative's comments included; "Very safe," "Without a doubt" and "I have no concerns, the staff are always attentive to [person's name] needs."
• The provider had clear policies and procedures in relation to safeguarding adults. Staff had received training in safeguarding adults and were able to tell us the correct action to take if they suspected people were at risk of abuse and/or avoidable harm. One staff member said, "I do not have any concerns about people's safety and if I did, I would report it to the registered manager." Another said, "I would tell the district nurse or ring the local authority."

Learning lessons when things go wrong
● Systems were in place but had not been completed robustly to demonstrate that accidents and incidents were being effectively monitored, reviewed or used as a learning opportunity. This meant that when things had or went wrong, the potential for re-occurrence was high because insufficient action had been taken to review, investigate or learn lessons. For example, in relation to the management of falls.

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

At the previous inspection we found people were not always supported to have maximum choice and control of their lives as staff were not consistently applying the principles of the Mental Capacity Act 2005 (MCA). This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found not enough improvement had been made and the provider was still in breach of regulation 11.

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 MCA 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.

- People were not always supported to have maximum choice and control of their lives.
- We reviewed a number of people's capacity assessments and best interest decisions and found the forms had been poorly completed. Some of the information recorded showed a lack of knowledge and understanding of the principles of the MCA.
- None of the MCA contained any information about how people were being supported to understand, retain, weigh up or communicate their decision.
- Information contained within one person's MCA suggested that conclusions had been reached before the assessment had been completed.
- An MCA had been undertaken on one person we were later told had capacity and were able to consent.
- One person's consent form indicated the person had signed and dated their record. appeared to have been signed and dated by the person. We checked this with staff who confirmed the person's relative had completed the document on their relative's behalf.

• We found where some restrictions had been placed on people's liberty to keep them safe, staff did not recognise their actions as restrictive practice. For example, the use of bedrails. People's capacity to consent to these arrangements had not been assessed nor had staff followed a best interest process.

• We discussed what we found with the registered manager, who acknowledged there was still some learning that needed to take place and accepted that this was reflected in the quality and standard of documentation.

The failure to properly assess and record people's capacity and best interest decisions risked compromising people's rights. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• People's weights were regularly recorded and people were provided with fortified meals and snacks to increase their calorie intake. The chef was aware of people's likes/dislikes, special diets and nutritional requirements. However, we found where some people had been identified at high risk of or had recently lost weight. Care plans did not provide care staff with any guidance or detail any action they should take or that had been taken. For example, monitoring the persons food and fluid intake and/or liaising with other healthcare professionals.
• Records showed and staff confirmed that where people had been identified as high risk of malnutrition, staff were not consistently recording their food and fluid intake. This meant the registered manager was not able to assure themselves that people were having enough to eat and drink or provide accurate information to healthcare professionals.
• We discussed what we found with the registered manager who said the lack of recordings had been partly due to a new computerised care planning system which was not fully embedded. And accepted the current standard of record keeping was not good enough.

The failure to complete accurate records of the care and treatment provided is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• People told us they liked the meals provided, they had plenty to eat and a good choice of food. One person said, "The food is really good, just the way I like it." Another said, "Very good, particularly the puddings." Relatives did not raise any concerns about the standard of food provided. One relative said, "Mum eats very well. She was very particular as she always did her own cooking, but she likes the food. They cater for her specific needs and always offer her diabetic sugar free puddings and snacks". "Another said, "Very happy with the food and there is plenty to drink as well, [person's name] always has a fresh jug of water or squash in her room."

Staff support: induction, training, skills and experience
• People were supported by staff who had received training to help ensure they could meet people's needs safely and effectively. The services training matrix showed staff had received training in a variety of subjects such as, safeguarding, infection control, moving and handling, health and safety and medicines. Specialised training was also provided that reflected the needs of people living at the service such as, dementia training, diabetes and stroke awareness.
• Relatives we spoke with did not raise any concerns about staffs' skills. One relative said, "Mum has a specific need and they made sure, staff were trained up before she moved in."
• Staff felt supported and valued by the home's management team. Staff were given the opportunities for regular supervision of their work performance and ongoing competency checks.
• Group supervisions were also held to share knowledge and good practice or to address concerns.
• The registered manager told us that all staff completed an induction and did not work unsupervised until

they had been assessed as competent to do so. We reviewed two staff files and found induction paperwork had not been fully completed.
• We discussed what we found with the deputy and registered managers who told us this had been an oversight. Both were experienced care staff and explained due to the impact of the pandemic on staffing levels, they had not managed to fully complete their normal processes/records.

We recommend the registered manager reviews the systems in place to ensure that all staff have completed an induction specific to the service and the people they support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

• Assessments identified people's care needs and care plans mostly provided staff with guidance on how to meet these needs in line with best practice guidance and people's preferences.
• People and their relatives where appropriate, had been involved in the planning of their care. People told us their care and support was provided in a way they liked and their wishes were respected.
• Good communication between care staff meant people's needs were well known and understood within the team. Although some of this information was not fully documented.
• Records showed referrals were made to the GP and community nursing services and other healthcare professionals when required. However, we found one referral had not been made in a timely manner. People had opportunities to see a dentist and optician regularly or when needed.

Adapting service, design, decoration to meet people's needs
• Burnside Court is a large spacious building set over four floors with bathroom and toilet facilities. The service had been adapted to meet people's needs and was clean and decorated throughout.
• People were encouraged to decorate/ personalise their bedrooms with objects, photographs and individual furniture to make them feel more at home and reflect their personalities. Relatives we spoke with told us whilst the building was dated in places, they had always found it clean and homely. One relative said, "It's an old Victorian building which has recently had some new floors put down and painted, It's clean and bright with fresh flowers in the conservatory." Another said, "I don't think it's a user-friendly building, the corridors are narrow but its clean and tidy."

Requires Improvement

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 for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection we found the provider had failed to ensure systems were in place to demonstrate the service was being effectively managed. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Continuous learning and improving care

• The registered provider and manager did not have sufficient oversight of the service to ensure people received care and support that promoted their well-being and protected them from harm.
• This was the third consecutive inspection where we found breaches of regulation and the service was rated 'requires improvement.'
• The oversight and governance of the service was inadequate in identifying the serious failings in relation to the safety of the service as detailed in the safe section of this report.
• Systems and processes to monitor the service were not being regularly undertaken. For example, medication, accident and incidents, health and safety, and environmental audits had not been undertaken for some time. This meant governance systems were not always effective, did not drive improvement and did not identify the issues we found at this inspection.
• Infection control audits were not taking place, this was particularly concerning due to the risks associated with the coronavirus pandemic.
• People were not protected from the risk of harm as they were living in an environment that may not be safe. Premises checks had not been completed, this meant risks to people's health and wellbeing were not being identified, assessed or mitigated. For example, fire safety checks had not been carried out for a number of months as the member of staff responsible for fire safety had left and this task had not been reassigned to another staff member.
• The provider had not ensured the staff understood the principles of the MCA. This lack of knowledge and understanding risked compromising people's rights.
• The lack of effective leadership at times did not promote and ensure a positive and person-centred culture within the service. For example, we found staff were using a communal hairbrush when they were not able to locate a person's own brush. When asked staff told us they wouldn't use this hairbrush on their own hair but did not recognise this as institutional practice or consider the impact this would have on people's sense

of self-worth or self-esteem.
• Records were not always accurate and had not always been updated to reflect changes in people's needs. For example, care plans and risk assessments were not being regularly reviewed/updated and daily care monitoring records were not being consistently completed by staff.
• Following the previous inspection February 2020, the provider was asked to complete an action plan to show what they would do and by when to improve. This was not received by the Commission. This meant we were not able to see what actions the service had taken to achieve compliance .
Systems were either not in place or robust enough to demonstrate the service was being effectively managed and there was a clear lack of oversight. This potentially placed people at an increased risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered and deputy managers had been open and transparent throughout the inspection process and spoke passionately about the people they supported and their commitment to getting it right. They recognised that governance arrangements had slipped, and the service was not where it needed to be. The registered manager told us that the impact of COVID 19 on staffing had significantly impacted on their ability to keep up to date with general paperwork and governance systems as they were providing care and support.
• Feedback from people and their relatives showed they were very happy with the care provided by staff and they had confidence in the leadership and management of the service. Comments included; "Mum likes it there she has improved tenfold", "I can be very open with the staff and manager. If I ask for something it gets dealt with," "All the staff go above and beyond," [Registered managers name] is brilliant, it's very clear that she cares about the people she looks after I would trust her with my life. Nothing is too much trouble" and "Very well run, they have always kept us informed. We are thrilled, it's a lovely safe home and mum tells us she is very happy there."

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 registered manager was aware of their responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The registered manager told us they were very proud of the team and the care they had given over the last two years through some very challenging and difficult times.
• Records showed people, relatives and staff were invited to share their views about the home at residents' meetings and through the use of questionnaires.
• Relatives said they were listened to and their feedback was welcomed.
• Staff told us they felt listened to, were supported by the registered manager, and had an input into the running of the home.
• The registered manager and staff had good working relationships with partner agencies. This included working with commissioners, safeguarding teams and other health and social care professionals. For example, an Occupational Therapist from Torbay Quality Assurance and Improvement Team had been working with the service updating people's moving and handing plans. And a nurse from Torbay Care Home Visiting Service was in the process of supporting staff in updating people's Treatment Escalations Plans (TEP). However, we found the service had been slow to make referrals or seek support when some people's care and health needs changed as documented within the safe section of this report.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the principles of the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way. Risks to people's health and safety had not been identified or mitigated. People were not always protected from the risk and spread of infection. Regulation 12(1)(2)(a)(b)(c)(d)(h)

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 had failed to ensure that recruitment procedures were operated effectively. Regulation 19(1)(2)

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 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to ensure compliance with the regulations. The provider had failed to maintain accurate, complete and contemporaneous records for each person living in the home. Regulation 17 (1)(2)(a)(b)(c)(f)(3)(a)

The enforcement action we took:

On the 20th April 2022, the Care Quality Commission served a warning notice under Section 29 of the Health and Social Care Act 2008 for failing to comply with Regulation 17, (1)(2)(a)(b)(c)(f), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was required to become compliant with Regulation 17, section (1)(2)(a)(b)(c)(f), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 17 May 2022.