Broadlands Nursing Home Limited

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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 caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 July 2016 and was unannounced. It was carried out by two inspectors. Broadlands Nursing Home has been previously inspected, but under a different registered provider. The provider deregistered and this service was registered under a new provider. This was the service's first inspection since registration under the new provider.

Broadlands Nursing Home provides personal and nursing care for up to 25 people. At the time of our visit there were 19 people using the service. The service did not have a registered manager in post although a manager had been recruited and was due to commence work shortly. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although people and their relatives felt that the service was safe, the provider did not always identify and manage risks to people's safety. For example, there were not sufficient measures in place to prevent people falling from upper floor windows or coming into contact with used razor blades. Medicines were not always stored safely because the temperature in the clinical room was too high. There was not an effective system to monitor accidents and incidents, identify themes and ensure appropriate action was taken. The provider was aware of this shortfall and was working towards putting such a system in place.

We also found that the provider did not always carry out the necessary checks on staff to ensure they were thoroughly vetted and of good character before their employment started.

When people were deprived of their liberty as part of their care and treatment, the provider had not ensured they were adhering to the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

We found three breaches of regulations during the inspection. These were in regards to providing safe care and treatment, fit and proper persons employed and safeguarding people from abuse and improper treatment. You can see the action we have told the provider to take with regard to these breaches at the back of the full version of this report.

Equipment such as hoists and fire safety equipment were regularly checked and serviced to ensure they were safe to use. People had individual risk assessments and management plans to keep them safe from risks specific to them. There were enough staff to meet people's needs and keep them safe. Apart from the high storage temperature, the provider managed medicines in a safe way.

Staff obtained people's consent before delivering care and when people did not have the capacity to consent to their care, the provider acted within legal requirements.

Staff received a variety of training and support to carry out their roles effectively. However, there was insufficient evidence that new staff and night workers received enough training and formal support for this.

People received a choice of nutritious food and drinks and their nutritional health was monitored appropriately. However, action taken by staff to ensure people ate healthily was not always recorded in care plans to ensure consistency in the delivery of care.

Staff were caring and respectful. People and their relatives told us the service was caring and they got on well with staff. Staff took time to get to know people and their communication styles and gave them appropriate support to make decisions about how their care was provided. Staff kept people informed about what was happening in the home. People told us staff respected their privacy and dignity.

People received personalised care that was responsive to their needs, because care plans took into account people's background, health conditions and preferences. Records showed people were supported in line with their care plans. The provider took steps to protect people from the risk of social isolation and provided a variety of group and individual activities that were appropriate to people's needs, preferences and abilities. Staff considered people's religious and spiritual needs when providing care.

People and their relatives fed back that the provider responded appropriately to their concerns. We saw evidence that the provider dealt with complaints promptly and to people's satisfaction.

The provider involved people, their relatives and staff in decisions about how the service was operated and any proposed changes that affected them. People, their relatives and staff felt that managers were approachable and they were able to express their opinions. The provider regularly asked people and their relatives for feedback to help them improve the service.

The provider had plans in place to develop and improve several aspects of the service and used monitoring visits and audits to monitor progress. However, the provider's audits were not always effective as they did not identify all of the issues that we found at our inspection. We also found the provider's policies were not regularly updated and had not been reviewed to ensure they remained consistent with current best practice guidance.

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. Although people and their relatives felt safe, the provider did not always effectively assess and manage risks around the home environment.

There were enough staff to keep people safe. However, they were not always thoroughly vetted to ensure they were appropriate for the job.

Medicines were mostly managed safely, although they were not always stored at safe temperatures.

Is the service effective?

Requires Improvement

The service was not always effective. The provider could not always demonstrate that they acted within legal requirements around depriving people of their liberty.

Staff received support including training and supervision to carry out their roles effectively, but there was not always evidence that new staff or night workers received the support they needed to do so.

People received a choice of nutritious food and had enough to drink to keep them healthy. They had support to access healthcare services when needed.

Is the service caring?

Good

The service was caring. Staff communicated with people in a way that was respectful, friendly and appropriate to their individual needs. Staff gave people information and support to help them make choices about their care.

People received care and support that respected and promoted their privacy and dignity.

Is the service responsive?

Good

The service was responsive. Care plans were personalised and took people's individual needs and preferences into account, including cultural and religious needs. There was a variety of

group and individual activities to keep people meaningfully occupied.

The provider responded appropriately and promptly to concerns and complaints raised by people and their relatives.

Is the service well-led?

Requires Improvement

The service was not always well-led, because audits and quality checks were not always effective in identifying and addressing shortfalls in the quality of the service.

However, there was an open and inclusive culture and the provider involved people, their relatives and staff in the development of the service. The provider routinely sought feedback and used it to improve the service.

Broadlands Nursing Home Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 July 2016 and was unannounced. It was carried out by two inspectors. Before the inspection, we reviewed the information we held about the service. This included notifications that the provider is required to submit to us about important events that take place at the location. The provider also completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted commissioners from the local authority social services to get their views about the service.

During the inspection, we spoke with three people who used the service, two relatives of people who used the service, four members of staff and a senior manager. We also looked at three people's care plans, four staff files, three people's medicine records and records relevant to the management of the service such as staff rotas and maintenance records.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt safe in the home.

Accident and incident records showed that staff responded promptly and appropriately to these. However, there was no system in place to analyse accidents and incidents for possible trends, which meant that the provider might not notice underlying causes of some accidents and incidents. One person had sustained two minor injuries from possible falls within a month and while each injury was appropriately treated, staff had not recorded them on a body map or other document that might have helped to identify a possible underlying cause. Managers told us they had begun to put an accident and incident analysis system in place to resolve this, but it was not yet operational.

Some environmental risks to people were not adequately managed. We noted that sharps bins containing used razors were left in bathrooms. Although these were lidded, the opening in the lid was large enough for people to tip the waste out, if they wanted to. This put people at risk of harm from sharp objects and potential infection. We spoke to staff, who told us they would move the bins to the locked sluice room. We also found that restrictors on upper-floor windows were not tamper-proof and we were able to override them easily by hand. This meant that there were not sufficient measures in place to reduce the risk of people falling from height through windows.

The provider was not complying with their own policy on the safe storage of medicines. Records from daily checks showed that on six days in the two weeks preceding our inspection the temperature in the clinical room where medicines were stored had risen above 25 degrees Celsius. According to guidance issued by the Royal Pharmaceutical Society, this is too hot and may result in medicines becoming ineffective or even harmful to people. Managers told us the provider had promised to install a cooling device in this room but had not yet done so.

The above issues indicated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records showed that the provider vetted new staff by obtaining proof of identity and qualifications and carrying out criminal record checks. However, one member of staff had not supplied a full employment history, which is a legal requirement, and the provider had not obtained references for three of the four staff whose files we checked. This meant the provider had not taken all reasonable measures to ensure staff were of good character and suitable to work with people using the service.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was information displayed in communal areas of the home about safeguarding people from abuse. This included how people and their visitors could raise the alarm about any suspected abuse. We saw evidence that if people presented with any unexplained marks on their bodies staff recorded these, with

photographs if necessary, reported them appropriately and monitored the person for any further marks. This helped to ensure that the service responded promptly and appropriately to suspected physical abuse. Staff we spoke with demonstrated an awareness of how to recognise and report abuse.

The deputy manager told us they managed staffing levels by looking at rotas on a weekly basis and considering the needs of the people using the service. At the time of our visit there were extra staff working due to the needs of one person who required one-to-one care to keep them and other people safe. We checked staff rotas and confirmed that the staffing levels set for the past month had been met and there was always a qualified nurse on shift. Records showed that staff were allocated to the person on one-to-one care on an hourly basis to ensure the care of the person was equitably shared among staff.

Managers told us the local fire brigade had recently carried out a fire safety inspection at the premises but they had not yet received the report. We toured the premises and found there were suitable fire doors with automatic closers in place and that fire extinguishers had been checked and serviced. Fire exits were clearly marked and the evacuation procedure was displayed where people and visitors could see it. Each person had an individual evacuation plan to ensure they were appropriately supported in an emergency.

People had individual risk assessments and management plans for risks specific to them, such as those presented by diabetes or dementia. Common risks such as those related to falls, malnutrition and developing pressure sores were also assessed with management plans in place. The risk assessments were reviewed monthly to help ensure they were up to date and covered the current risks for each person. The actions staff needed to take to reduce the risks were clearly described.

Equipment such as hoists and call bells were regularly checked and serviced to ensure they were safe and in good working order. Staff used appropriate moving and handling techniques to assist people during our inspection, using equipment as prescribed by their care plans. Where people used wheelchairs, we saw staff checking they were safe and putting footplates in place before moving people. Each person had a moving and handling assessment and care plan on file, which set out the specific support and equipment they needed.

We looked at the provider's management of controlled drugs. These were kept appropriately in a locked cabinet. We checked the stocks of a random sample of medicines including controlled drugs and found they were correct. Receipt, disposal and administration of controlled drugs were signed for by two qualified nurses to reduce the risk of harm coming to people through poor management of controlled drugs.

People's care plans contained information about the medicines they took. Staff assessed people's ability to manage their own medicines. People had guidelines in place about the safe administration of medicines to be given as required. There was information about side effects and these were monitored. People were offered regular tests and checks where the medicines they were taking made this necessary, for example attending a warfarin clinic.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about the knowledge and abilities of staff. The deputy manager told us they involved all staff in discussions about good practice and how to provide effective care to, for example, people with dementia. They told us they did this in daily handovers, supervision and team meetings. Nursing staff told us how they shared good practice with other staff and helped them to learn skills and to care for people empathetically.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (MCA). The 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. Staff we spoke with were aware of their duties and requirements within the MCA. We found that the provider had assessed people's mental capacity to consent to different aspects of their care. The assessments covered criteria specified in the MCA Code of Practice. Where people were determined not to have capacity, there was evidence that "best interests" decisions had been made, involving those who knew the person well such as family and doctors, in line with the MCA Code of Practice. However, we noted that there were no dates on the assessments. This meant we could not be sure whether they were being reviewed regularly, as in some circumstances mental capacity can fluctuate over time.

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. The application procedures for this in care homes and hospitals are 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 were being met. One person was supported with one-to-one care throughout the day due to risks presented by their behaviour and this may have amounted to a deprivation of liberty. Although we saw evidence that the provider had given themselves an urgent authorisation to deprive the person of their liberty under DoLS while they applied for a standard authorisation under DoLS, this was two months before our visit. The DoLS Code of Practice states that service providers can only put emergency measures in place to deprive people of their liberty for a maximum of seven days. We did not see evidence that the provider had applied for an extension to this period as set out in the DoLS Code of Practice. They had also not chased up the local authority in relation to the application they had submitted for the standard authorisation to deprive the person under DoLS. The provider had not thoroughly assessed the specific risks around the person's behaviour or put in place written guidelines directing staff how to respond to any risky behaviour the person presented. Therefore, they could not demonstrate that they had done all they reasonably could to care for the person in the least restrictive way possible whilst ensuring their safety and that of others.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us people who had the capacity to do so were always involved in planning their care. During our

inspection, we saw staff asking people for consent and obtaining it before carrying out care tasks. This showed that, where people had the capacity to consent, the provider was acting within legal requirements and ensuring that people's rights were upheld.

We saw evidence that new staff were required to complete an induction. This helped to ensure they were equipped with knowledge that they needed to carry out their roles effectively before starting to care for people unsupervised. Staff told us they were shadowed when they first started and got support from senior staff and the team. However, when we looked at the records of a member of staff who had commenced work at the service in February 2016, we found that although they had completed an induction there was no record that they had received supervision or other support since that time.

We looked at training records and saw that staff had access to specialist training to equip them with the skills and knowledge they needed to care for people with specific needs such as catheters. Staff we spoke with felt the training was good and helped them to care for people effectively. However, we noticed some gaps in the training. For example, most night staff had not received training in health and safety or fire safety, meaning there was a risk that night staff did not have access to knowledge they needed to carry out their work effectively.

People and their relatives told us the food served at the home was "nice." There was a "hydration station" in the communal dining room equipped with a choice of cold drinks freely available throughout the day. We observed staff offering one person a choice of cold drinks. When the person asked for tea instead, staff encouraged them again to drink a cold drink as it was a warm day, but when the person declined they said they would get tea. Giving people a choice of drinks they liked helped ensure they drank enough fluids to remain hydrated.

Staff informed people when meals were ready but respected their choices around mealtimes. One person told staff they were not hungry when lunch was offered and the member of staff said that was fine and they would come back later to offer the meal again. We saw some people using special equipment to help them eat, such as a plate guard which prevents food falling off the plate. This helped to ensure people were able to eat enough food without compromising their independence. Where people needed staff to assist them, staff were encouraging them and telling them what was being served to them.

Staff kept food and fluid intake records for people who were at risk of malnutrition or dehydration. Staff also assessed and monitored these risks on a regular basis. We saw examples of where people were at high risk or had lost weight and staff had taken action such as involving relevant health professionals or discussing with people's family how to encourage them to eat more. In one case, we noted that the person had gained weight every month since staff had put these actions in place. However, this was also true for a person whose assessment stated they were obese and there was no assessment of the risks around this and how the person should be supported to manage their weight. We asked staff, who told us they gave this person smaller portions to eat but because this was not recorded in the care plan there was a risk that the person's nutritional needs would not be consistently met.

Care records showed that where the service could not meet a healthcare need, staff referred people to the appropriate service and gave ongoing support as prescribed by health professionals. There was evidence that people regularly saw doctors, dentists, opticians and chiropodists. One person with recurrent pressure ulcers was referred to a tissue viability nurse and staff had incorporated their instructions and advice into the person's care plan about how to care for their skin. We saw evidence in care records that if people showed symptoms of minor illness, staff monitored this appropriately.

Good

Is the service caring?

Our findings

People told us, "I find living here quite nice. The company is nice" and "It is very friendly." A relative told us, "It's like a family" and another said they rated the care "20 out of 10. The staff are angels in disguise." The home had a pleasant atmosphere with staff chatting and joking with people in a friendly way and culturally appropriate music playing.

One person told us, "[Staff] have taken time to get to know me." This was further demonstrated by information in people's care plans. Each person had information about their life history, social preferences (for example whether they preferred company most of the time or liked to be in private), favourite things and what was meaningful to them. There was a board with pictures of staff working at the home to help people identify staff. This was designed to help people familiarise themselves with staff and build positive caring relationships. Staff told us they felt it was important to take time to talk to people and get to know what they liked.

Care plans considered people's emotional needs. For example, one person's care plan stated that if they were upset staff should support them to make telephone calls to their family. Another person's care plan stated that they sometimes forgot that their loved ones were deceased and asked about them. Staff were instructed to respond sensitively, saying the relative was "not here at the moment" and only to say the relative had died if the person asked if they had. This showed how staff worked to avoid repeatedly distressing people whilst maintaining honesty with them.

We saw staff supporting people to make decisions about how they would like to be cared for. One person was coughing and a member of staff responded sympathetically, told them about a medicine they could take and asked them if they wanted it. Staff communicated with people in ways that were appropriate to their individual needs. For example, we observed staff speaking particularly clearly and slowly to a person who was hard of hearing, calmly and kindly to a person who appeared distressed and using simple phrases and yes or no questions when speaking to a person living with advanced dementia. One person's relative told us, "[Staff] really know my [relative]. She can't verbalise what she needs, but they have got to know her actions and know what they mean and what she wants."

There was evidence that people's relatives were involved in making decisions about their care. Relatives told us they were always involved and had opportunities to go through care plans and ensure their relatives were receiving the right care for them.

Staff kept people informed about what was happening. We observed staff reminding people about what activities were taking place later that day. We heard one person say, "I want to get up" and a member of staff responded that they needed to get a wheelchair first so the person knew why they were leaving. We saw staff continually speaking with people while assisting them with equipment such as hoists to ensure they knew what was happening and to preserve their dignity.

People told us, "The staff are good. They treat me with respect" and, "You get your privacy." We observed

that people were dressed in weather-appropriate, clean, well-fitting clothes and suitable footwear. Staff had made sure people's hair was brushed and some people had nail varnish or decorative hair clips on.

Staff demonstrated an awareness of how to respect and promote people's privacy and dignity. One member of staff told us they always asked people if they wanted help with their personal care rather than assuming they did.

Good

Is the service responsive?

Our findings

Staff supported people to spend their time according to their needs and preferences. The communal space was set up in such a way that people could choose whether to socialise with a larger group, one-to-one with a friend or visitor or sit alone. Care plans contained information about people's social needs and these were met. For example, one person's care plan stated that they loved company and hated being alone, and we saw staff interacting with this person throughout our visit. A second person was more independent and staff spoke with them less as they were socialising with another person who used the service.

Care plans were personalised and based on information specific to each person. These included people's goals and their progress against these. Each care plan set out the specific support people needed in each area to help ensure they received personalised care that was responsive to their needs. For example, one person who was living with dementia had a care plan that instructed staff to carry out one-to-one activities with them and how to help them avoid becoming disorientated. We saw that people who were at risk of developing pressure ulcers had turning charts in place, showing that staff had repositioned people regularly to reduce this risk. Where people were at risk, they had monthly skin integrity assessments and appropriate action was taken to respond to their individual needs in this area.

Each person had keyworkers, who are members of staff assigned to ensure that their needs were met on a daily basis. We observed that each person had opportunities to engage with staff throughout the inspection. The deputy manager explained some of their work to protect people from the risks of social isolation, for example encouraging people not to stay in their rooms if they were able to engage in activities. People were able to access communal space, including a well-maintained garden. People's bedrooms were personalised according to their tastes.

There was a designated member of staff in charge of activity planning. During the inspection we observed this member of staff engaging various people in one-to-one activities appropriate to their individual needs and abilities. An activities timetable showing group activities planned for each day was displayed where people could see it alongside information about upcoming birthday celebrations. We heard staff reminding people about a group activity that was taking place on the day of our inspection.

People we spoke with confirmed that planned activities took place. Activities were varied and included reminiscence visits from army personnel, singing songs from musicals, watching films and having ice cream. Records showed that people were offered alternatives if they did not want to do planned activities. Staff monitored the activities people took part in or declined to help them plan future activities that people would like. Care plans included information about people's hobbies, favourite music and TV programmes and what they liked doing. Records showed that staff took these into account when planning activities. Staff told us there was a major outing organised twice a year. We saw photographs from previous outings and information was displayed about a trip to a popular tourist attraction due to take place the month after our inspection. The home had recently held a fete that people and their relatives had been involved in planning and running.

Where people had religious beliefs this was specified in care plans. Staff told us they tried to meet people's religious needs where possible. We heard one person talking about church several times during our visit. Staff told us this person no longer attended church services because they were unable to recognise where they were, but they also said staff sang hymns with the person and put religious television programmes on for them. The service had equality and diversity policies to help ensure people received care in line with their cultural and religious needs.

Relatives told us managers listened to their feedback and made changes in response, where necessary. One relative gave an example of an activity they had suggested, which was now taking place regularly. They told us, "They will always listen to ideas" and "They are very responsive."

We looked at complaints records and found that where people had complained, the provider responded promptly and always acknowledged complaints within three working days. The provider noted any follow-up action they took and we saw that all recorded complaints had been resolved to people's satisfaction. Where people and their relatives had expressed concern via questionnaires or meetings, managers were able to tell us what action they had taken to resolve these and this was recorded in minutes of meetings where relevant. For example, some relatives had expressed concerns about whether people's hair was styled as they liked it and this had been discussed with the hairdresser.

There was a meal comments book where staff recorded comments people made about their food. The chef told us they reviewed these and made changes in response to any negative feedback.

Requires Improvement

Is the service well-led?

Our findings

People's relatives were invited to meetings to keep them informed about planned events and changes to the service and to involve them in developing the service. At the last meeting a month before our visit, staff had asked relatives' opinions and discussed their feedback about food choices and activities. Relatives told us they could "talk about anything" at the meetings. Staff also informed relatives about plans to make changes to the building and the new manager who had been appointed. The service had recently held a summer fete, which people and their relatives had been involved in planning and running. This showed that the provider promoted a positive, inclusive culture at the service.

We found that the provider's audits and checks had not identified the issues we found during our inspection, such as risks to people's safety presented by the environment and missing information in staff files. This showed that the provider's system for assessing and monitoring the quality of the service was not always effective . We discussed this with managers, who told us the provider was aware of this and was in the process of developing a more effective quality assurance system.
We looked at a sample of audits and checks carried out at the home. A medicines audit had been carried out the month before our visit. However, this had been filled out incorrectly meaning that stock levels were not properly checked and the figures given suggested incorrect numbers. This meant the audit was not effective in checking whether or not medicines were managed safely. A previous audit in February 2016 was filled out correctly and showed no areas of concern.

At the time of our visit there was not a registered manager in post. The provider had appointed a new manager, who was due to start work within a month of our visit. In the interim there was a deputy manager in post, a registered nurse who was supported by a senior manager who was also a registered nurse. One person's relative told us the deputy manager was "fantastic" and that they could speak to the managers at any time. Staff told us managers were friendly, helpful and flexible and that the team worked well together.

The senior manager told us about the staff development plan, including a clinical support worker post. This was to involve extra training and qualifications for staff to create a new opportunity for staff development and more senior staff in the team. The plan also included allocating specific responsibilities, such as safeguarding and dementia champions, and the managers told us they had begun rolling out training for this. The provider had facilitated one member of staff to become a trainer in safe moving and handling of people and they were providing training to staff across the provider's services. Another member of staff told us they had just started leadership training.

Managers told us that a representative of the provider visited the service regularly to monitor the quality of the service and the senior manager also visited regularly. They told us they discussed areas for improvement identified by these visits with the staff team. Records of these visits showed that the representative had spoken with staff about the support they were receiving from management.

We saw evidence that there had been a senior managers' meeting the week of our visit, in which they discussed best practice and the plans for development of the service. We noted that the service had a

number of policies and procedures in place to help ensure staff delivered care consistently and in line with agreed standards. However, those we looked at had not been updated since 2010, meaning they may not have been based on current best practice.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not fully assess risks to the health and safety of people using the service or do all that was reasonably practicable to mitigate such risks. This included ensuring the premises were safe and safe management of medicines. Regulation 12(1)(2)(a)(b)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that when people were deprived of their liberty for the purpose of care or treatment this was only carried out with lawful authority. Regulation 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not effectively operate recruitment procedures to ensure that persons employed for the purposes of carrying on regulated activities were of good character. Regulation 19(1)(a)(2)(a)