MasterCare Residential Homes Limited

BelleRose Residential Home

Inspection report

14-16 Westland Road
Watford
Hertfordshire
WD17 1QS
Tel: 01923 353350
Website:

Date of inspection visit: 28 & 29 April 2015
Date of publication: 13/07/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection was carried out on 28 and 29 April 2015 and was unannounced. This was the first inspection carried out since the service was registered with the Care Quality Commission on 5 January 2015.

BelleRose Residential Home provides accommodation and personal care to nine people. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

On the day of this inspection, there were nine people living at the home. People supported by the service had varying degrees of mental health needs as well as requiring support with their day to day care needs.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLs) and

Summary of findings

to report on what we find. DoLs are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority in relation to people who lived at the service and were pending an outcome. Staff were fully aware of their role in relation to MCA and DoLs and how to support people so not to place them at risk of being deprived of their liberty.

People received personalised care and staff knew them well. Relationships between people who used the service, the manager and support staff were positive. We found that support staff were caring and responsive. However, several people told us that they felt disrespected by the NI. Care plans were well written and were reviewed on a regular basis. People told us that they were not involved in planning and reviewing their care.

The provider did not have an effective recruitment processes in place that protected the people who used the service. Frequent staff changes meant that people were not always supported by a consistent group of staff who they knew.

The lack of managerial support and guidance from the provider to the manager failed to ensure that people were provided with a consistent standard of care.

At this inspection we found the service to be in breach of the Health and Social care Act 2008 (Regulated activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

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

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
People who lived in the home were not safe.

Not all staff were aware of the actions to take to ensure that people living in the home were kept safe from harm. This included some staff who had not received safeguarding training.

People were not always supported by sufficient numbers of staff to enable them to receive safe and effective care.

Medicines were managed appropriately.

Inadequate

Is the service effective?
The service was not effective.

Some staff could not demonstrate that they had the appropriate skills and knowledge to meet people's needs.

Not all staff were aware of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs).

People were not always supported to eat and drink sufficient amounts and to maintain good health.

Inadequate

Is the service caring?
The service was not caring.

People were treated with kindness by staff but their privacy and dignity was not always respected by others.

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

Inadequate

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

People could not be confident that their concerns or complaints would be dealt with effectively or fully resolved.

The provision of activities did not meet the current needs or wishes of the people who lived in the home.

Requires Improvement

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

We found that the provider failed to work consistently with the manager to provide effective leadership. This had a detrimental effect on the people who lived at the home.

Inadequate

Summary of findings

The systems in place to monitor, identify and manage the quality of the service had not always identified or resolved issues found on our inspection.

BelleRose Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 28 and 29 April 2015 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience whose experience was in the support of people with a mental health need. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed all information we held about the service, which included notifications the provider had sent us. A notification is information about important events which the provider is required to send us. We also looked at recent reports from the local authority contract monitoring team.

We spoke with nine people who lived in the home, the registered manager, five support staff and the NI. We also observed how care was being provided in communal areas of the home.

Following the visit to the home, we obtained the views of other health and social care professionals about the quality of the care provided by the service, this included the local authority commissioners of the service.

Inadequate

Is the service safe?

Our findings

People were not adequately safeguarded from the risk of from abuse and degrading treatment. Although people gave us positive feedback about the staff we were made aware of concerns about one of the provider representatives. One person told us, they "Usually felt safe living in the service." One Another person told us, "The care staff are very good and do their best to ensure that we are kept safe". We saw that people were able to spend time where they wanted to within the home . We were told that people were provided with a bedroom door key and a key to their front door. This meant helped to ensure that people had the freedom to come and go as they pleased.

We were informed that a representative of the provider organisation spoke in a manner that was disrespectful. We brought these concerns to the attention of the local authority safeguarding team after our inspection so that they could be fully investigated.

People were not supported by staff who knew how to recognise and report abuse. Three staff told us they had received training on how to recognise abuse and described how they would report abuse. However, we were told that some members of staff had not yet received this training and when we spoke with two staff they were unable to describe any examples of abuse or demonstrate how they would raise concerns that related to abuse. We found concerns during our visit that we reported to the local authority safeguarding team which had not been identified and reported by staff. Further details of these concerns are explained in the body of this report.

The failure to ensure that all staff were adequately trained and to identify matters which required reporting to the Local Authority was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the home told us the staff, "Did their best". Another person told us there was, "Always new staff coming and going.". People said they found this unsettling, as they were unable to get to know the staff before they left again. Another person told us that, "'Lots come and go quickly... they [Staff] used to be quite regular but now they go quickly." They went on to say." One person told us, "Some stay like a couple of weeks, others years." More recently 'it's like they all go, just when you get used to them.".

We observed, and staff told us, there were two members of staff on duty at any given time. Staff told us the manager was responsible for assigning staff to shifts. On the day of our inspection the rota confirmed these staffing levels were accurate. We were told that new members of staff were rota'd on shift to "Shadow" the more experienced staff member as part of their induction programme. However, on both days of our inspection we observed that the new member of staff was used as the 'second' member of staff .This meant that there was only one trained member of staff on duty. We observed that new staff were left to assist and support people alone and without the support or guidance from the 'trained' member of staff. This put people at risk as on occasions, people displayed behaviour which challenged. This could have placed people at risk of harm.

The lack of suitably competent and experienced staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at two recruitment records and saw that all staff had been subject to a criminal records check through the Disclosure and Barring Service. However, we also found that both of these records showed that references had been provided from relatives/friends of staff rather than previous employers and that employment histories had not been checked. The home's recruitment and selection policy (2.2) states 'Before any unconditional offer is made, checks must be made as to the candidate's eligibility from the point of view of character references, education and professional attainment.

We saw from the recruitment records and from the staff rotas that two staff had been appointed were related to the NI of the service. Point (2.4) of the recruitment and selection policy states 'Any potential conflict of interest must be declared as soon as it comes to light. Examples of likely conflicts of interests would be if a person directly involved in any stage of the selection process has (or has had) a personal relationship with one of the applicants, or is related to one of the applicants, or has prior knowledge of one of the applicants outside of the work environment which could in any way effect the decision they make. Normally the assessor should stand down as they are

Inadequate

Is the service safe?

unable to give a fair assessment of the applicant.' This meant that the required checks to ensure that only suitable staff were employed at the home had not been satisfactorily completed.

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

We saw several areas of the home that required attention and were in a state of disrepair. This included three beds that required replacing. One person showed us their mattress and told us that it was, “Uncomfortable because the springs are sticking through it.”. There were also two nails that stuck out from the base of the bed. This person told us that 'It's been like this for a few months. They said, “ I'm scared I'm going to catch my leg on it.”. The armchair in this person’s room was also ripped with the foam lining exposed and there was no fire safety guidance or kite standard attached that confirmed it was safe to be used. We saw another two mattresses that were old and threadbare with the springs clearly visible on both these mattresses.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people’s safety had been assessed. People had been involved in the assessment and we saw that these were reviewed regularly. Individual risk assessments with action plans had been provided for staff with information which described how to manage risks safely when supporting people. For example, we saw that risk assessments had been completed with regard to people going out of the service and for the risks associated with road safety and using public transport. However, some staff members were unable to demonstrate an understanding of the impact of the risk assessments and their benefits.

Medicines were stored safely. Medicine administration records were in place and the recording of medication was accurate. Staff we spoke with told us they had received updated training in medication administration within the past year. Following training, staff were regularly monitored and checked to ensure they were competent and to demonstrate their knowledge. Staff told us they followed appropriate guidance with regard to the administration, safe storage, and disposal of medication. We saw that medication audits were undertaken periodically as part of the overall quality monitoring at the home. We saw that there were safe systems in place to observe, assess and monitor people who self-administered their own medication. This included an initial assessment of the person’s abilities and understanding and regular monitoring of the weekly medications medicines given out to people.

Inadequate

Is the service effective?

Our findings

People were coming and going to the kitchen and making drinks. People told us they were supported to buy and cook their own food and that they had a 'budget' to buy their food. We were informed by the NI that the weekly food allowance was 270 pounds per week. This was divided between the nine people who lived t the home, giving them thirty pounds per week to purchase their food. One person told us that they struggled to manage on the money they were allocated. Another person told us they often had, "Little food" as if they smoked as well; they had to choose between eating and smoking. This meant that people could be placed at risk of not being provided with adequate funds to ensure they received a nutritionally balanced and healthy diet.

We asked staff how they ensured people were supported to eat and drink sufficient amounts. Staff confirmed that people were responsible for buying and making their own meals. People's nutritional needs were not routinely monitored, although staff told us people were weighed monthly and if there were any concerns about peoples weight or poor nutritional intake they advised people to make healthy choices. One person described the food as "inadequate".

The lack of provision of suitable and nutritious food was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that new staff received an induction over a period of six weeks which included a period of shadowing an experienced member of staff who knew the people in the home well. However, we saw two new members of staff had commenced work after only one day of induction training and without any shadowing shifts completed. Both of these staff had only been inducted into the building and had received no training before being placed on shift. This placed people at risk from staff who had not been inducted or appropriately trained to carry out their role effectively or safely.

Three staff we spoke with told us they felt trained and supported to effectively carry out their role. Staff told us they had received regular supervision from the manager. Three staff told us, and the training records we reviewed confirmed, that these staff had received training in a number of topics including fire awareness, infection control, and food safety and safeguarding people from the risk of abuse. All staff received regular supervision sessions from their line manager. Staff told us that this equipped them with the knowledge and skills required to deliver care effectively.

Some staff had not received training in the MCA or DoLs. A member of staff told us it was, "About ensuring people got choices and do what they want." Two staff had no understanding of the Mental Capacity Act or the Deprivation of Liberty Safeguards (DOLS). This meant that the care provided may not be in accordance with the MCA. Staff did not know what steps were needed to protect people's best interests. In addition, staff were unclear on how to ensure that any restrictions placed on a person's liberty were lawful. This meant that people may be at risk of harm from staff who had not been adequately trained or possess the knowledge or skills to ensure that people were appropriately assessed.

People who lived in the home told us that consent was sought before care or support was provided. For example, when giving people medicines. However, some staff were unclear about the requirements required to obtain consent and when to review consent.

People told us that they were able to visit their GP as needed. They gave us examples of visits to the optician, general practitioner and dentist. One person said that care staff had accompanied them to hospital. This helped to ensure people's day to day health care needs were monitored and supported.

Inadequate

Is the service caring?

Our findings

People were communicated with by staff with a warm and caring approach. For example, we observed one person in the kitchen who was being supported to prepare their mid-day meal. The staff member offered advice and guidance in a kind, patient and caring manner. We saw staff talked with the people they supported with kindness and warmth. One person said that staff were, “Always here to help you, if you need it.” Another person told us that the, “Staff are all very, very good. They're kind and brilliant.”

However, people expressed concerns about the NI. One person said, “It does affect us all because we think they are not as caring as they are meant to be. It upsets us all.”

People told us a representative of the provider often visited the home night or day but came in without knocking or ringing the doorbell. One person told us that they felt this was, “Disrespectful because it is our home.” We were told that the majority of staff respected people’s privacy and knocked on people’s bedroom doors before entering. However, one person told us that staff entered their bedroom without knocking. They said, “Sometimes staff just walk in ... they don't knock. I could be naked .” They added that sometimes staff, “Just go up to your room without your permission.” This meant that people’s privacy was not always respected.

People told us, and staff confirmed, that they were only allowed to use the washing machine once a week and the building that housed the machine was kept locked. People had to ask a staff member to open it when they wanted to use it. One person explained how this caused them unnecessary upset and distress as they needed to wash their clothes more regularly in order to maintain their personal hygiene. This meant that people were not being treated with respect and dignity.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that no one who currently lived in the home had an advocate. We saw that there was no information displayed or available to give to people on how they could find an advocate if they wished to access this service. One person told us that they had not been made aware of any advocacy services when they had moved into the home but felt they could ask the manager if the need came up. This meant that people were not provided with the opportunity to access independent support and guidance from an advocacy services.

We saw that all confidential information that related to people who used the service was securely maintained and locked within the main office. This helped to ensure that people’s confidentiality was protected.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff knew the support they required and provided this for them. They said that staff responded to their individual needs for assistance. One person said, “I’m very well looked after.”

The information contained within the care plans we viewed reflected the person’s individual needs and contained up to date risk assessments. For example, there was a risk assessment for people who managed their own medication, road safety risk assessments and substance mis-use assessments. We saw that the care plans had been reviewed within the past six months.

Most staff were knowledgeable about the people they supported and were aware of people’s preferences as well as their health and support needs. However, two out of five staff were not aware of people’s needs or preferences even though they were expected to provide care and support to people. One member of staff told us how they always encouraged people to be as independent as possible by ensuring their care plans identified aspects of independent living skills where they required support and direction. For example, preparing their meals, washing their clothes and managing their finances.

Although we saw that people had signed the care plans we viewed, six out of nine people could not recall seeing their care plans since they moved into the service. One person said, “I think I've got one ... I haven't got a copy.” Another person told us, “I read it last year, I think, but couldn’t remember what is included.” One person told us, "I have a meeting every six months to review it.” We were told by one person, “I don't say anything.” They went on to say that they were worried about “getting the blame” if they said something 'wrong. People told us that their keyworker attended the reviews. They added, “I didn't know [name of staff] was my keyworker until last week.”

Pre- admission assessments were undertaken to identify people’s support needs and care plans were developed stating how these needs were to be met prior to a person moving into the service. The manager told us how people and their families were encouraged to visit the service before they moved in. They said this would give them an idea of what it would be like to live in the service and see if their needs could be met.

People had their own bedrooms or self-contained flats within the home and had been encouraged to bring in their own items to personalise them. However, although people had displayed items that reflected their interests, which included pictures, photos and paintings, we saw that four out of nine rooms required re-decorating and were in a state of dis-repair. This included chipped wallpaper/ paint, broken and ripped furniture. We saw in one person’s room the lack of storage space caused them to leave several personal possessions on the floor. This gave these rooms an unkempt and neglected feel. One person told us that these issues had been recorded within the ‘repair’ book by the manager but we saw that these repairs were still outstanding on the days we inspected.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the home and staff were aware of the procedure to follow if they had a complaint. People told us that if they had a concern they would speak to the manager and an up to date copy of the complaints policy was seen and displayed within the home. The manager described the system in place to record complaints received, investigate them and record their outcome. The home’s complaints policy states ‘This policy is intended to ensure that concerns and complaints are dealt with promptly and properly and that all complaints or concerns are taken seriously.’ However, people told us that where they had made complaints directly to the NI they had not received a response and that their complaints remained unresolved. For example, one person had complained about not having a public telephone in the home for people to use and six people complained that the weekly food allowance was not enough. This meant that people were not always supported to raise complaints and these were not managed effectively.

The failure to respond to complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed view with regard to the activities provided. Although people's care plans had a weekly time table in place that included activities such as attending computer courses at 'Learn direct, attending a local day centre, accessing computers at the local library and support provided by Mind (The mental health charity).One person told us, “It's too boring here.” When asked what leisure activities there were at the home, they told us,

Requires Improvement

Is the service responsive?

“None really.” They also told us that, “One of the worst things about being in the home is we just stay in the house all day.” However we did observe that people could freely access the local community if they wished to. One person said that they would like more activities both within and outside the home but did say that they do have the opportunity to go swimming sometimes. Another person told us that they are supported to go fishing in the summer months. This meant that people did not always have a choice over what they wanted to do and people lacked social stimulation.

Inadequate

Is the service well-led?

Our findings

People told us that the found the manager approachable and supportive. However, we were also told that the NI raised their voice to people which had impacted on their mental health and wellbeing. They also raised concerns about the restrictions imposed that related to provisions and services. For example, only being allowed to use the washing machine once a week, and having an insufficient food allowance which did not afford adequate food or a healthy diet for people.

The “Statement of purpose” for the service included the statement that “the happiness, safety, security and well-being of our service users are paramount”. It described how people using the service “feel safe (and) are free from abuse” and that the accommodation is “of the highest quality”. During our inspection visits we found that the service provided did not meet the stated aims and objectives set out by the provider in their statement of purpose.

Resident’s meetings were held regularly, although none of the people we spoke with felt that they were involved in the running of the home or that their views were properly taken into account when decisions were made about the home. One person told us that they, “Would like to have more say and yes we should be able to come up with policies. Yes, that's important we do.”

The manager conducted monthly monitoring audits which included medication audits, financial audits, maintenance audits and health and safety audits. We saw the most recent audits were completed in April 2015. Although these audits had been completed they had not led to improvement in some key areas that we found during our inspection which had a direct impact on the well-being of people who used the service.

The lack of effective leadership and governance from the NI and defiance's in the monitoring and audits was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was available throughout the inspection and had a good knowledge of people who lived in the service , their relatives and staff. At the time of this inspection the manager divided their time between two homes, both located within the Watford area. We were told they spend fifty per cent of their working week in each service. The home currently has a deputy manager vacancy which was being covered by a deputy manager from the ‘sister’ home. People spoke very positively about the manager and told us that they were, “Very good”. Another person described the manager as, “A nice person and I think they are good manager.” During the inspection we observed the manager’s approach to be both consultative and respectful with people, taking time to listen to what people had to say to and offering a private place for discussions that related to personal issues.

Staff felt supported by their peers and they told us that they worked well together. We saw that staff would ask each other for support when needed to ensure people’s needs were attended to quickly.

We found that staff had the opportunity to express their views via staff meetings and handovers.

Staff told us they were encouraged to make suggestions to improve the quality of service provision by the manager. They did this either individually in supervision or in one of the regular team meetings.

This section is primarily information for the provider

Enforcement actions

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

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

The enforcement action we took:
We have formally notified the provider of our proposal under Section 12 (5) of the Health and Social Care Act 2008 to vary the conditions of registration in respect of the above regulated activities at BelleRose Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to ensure that all staff were adequately trained in the safeguarding of vulnerable adults and the failure to identify matters which required reporting to the Local Authority placed people at risk of harm.

The enforcement action we took:
We have formally notified the provider of our proposal under Section 12 (5) of the Health and Social Care Act 2008 to vary the conditions of registration in respect of the above regulated activities at BelleRose Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The provider failed to ensure that people were protected from the risks of inadequate nutrition and dehydration. The provider failed to monitor or record people's dietary intake to ensure people were receiving a nutritionally balanced diet.

The enforcement action we took:
We have formally notified the provider of our proposal under Section 12 (5) of the Health and Social Care Act 2008 to vary the conditions of registration in respect of the above regulated activities at BelleRose Residential Home.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People were placed at risk from unsafe premises and an inadequately maintained environment which placed people at risk of harm.

The enforcement action we took:
We have formally notified the provider of our proposal under Section 12 (5) of the Health and Social Care Act 2008 to vary the conditions of registration in respect of the above regulated activities at BelleRose Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider failed to respond and act on complaints made by people who used the service.

The enforcement action we took:
We have formally notified the provider of our proposal under Section 12 (5) of the Health and Social Care Act 2008 to vary the conditions of registration in respect of the above regulated activities at BelleRose Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The lack of effective leadership and governance by the provider and defiance's in the monitoring and auditing of systems failed to ensure people's health and welfare was protected.

The enforcement action we took:
We have formally notified the provider of our proposal under Section 12 (5) of the Health and Social Care Act 2008 to vary the conditions of registration in respect of the above regulated activities at BelleRose Residential Home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to safeguard the health, safety and welfare of people who used the service because there were not sufficient numbers of suitably qualified, skilled and experienced staff available at all times.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have formally notified the provider of our proposal under Section 12 (5) of the Health and Social Care Act 2008 to vary the conditions of registration in respect of the above regulated activities at BelleRose Residential Home.

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 failed to ensure the selection and recruitment policy was implemented effectively which placed people at risk of harm.

The enforcement action we took:
We have formally notified the provider of our proposal under Section 12 (5) of the Health and Social Care Act 2008 to vary the conditions of registration in respect of the above regulated activities at BelleRose Residential Home.