Haresbrook Park Limited

Haresbrook Park Care Home

Inspection report

Haresbrook Lane
Tenbury Wells
Worcestershire
WR15 8FD

Tel: 01584811786

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01 September 2020
10 November 2020

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18 December 2020

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
Haresbrook Park Care Home provides accommodation and personal care for up to 75 people. At the start of this inspection 25 people were living at the home. This number reduced to 20 people at the time of our final visit. The home is purpose built with all accommodation and facilities on ground floor level over two units.

Most people living at Haresbrook Park live with an advanced dementia related illness or mental health illness. County House unit has previously supported people with more complex health care needs and advanced dementia. Glen View unit has supported people who were more independent and live with a dementia illness or mental health need. At the time of the inspection everyone was living within Glen View.

People's experience of using this service and what we found
The service was not well- led. The providers did not have effective governance systems in place to maintain continuous improvement. The service has not been well-led for six consecutive inspections.

This resulted in some people not receiving safe care. Risks to people were not always identified and managed in relation to ensuring the environment was safe. Medicines were not always managed safely. There, were areas where staff were not following infection control guidance and procedures in relation to the Covid-19 pandemic.

Accidents and incidents were not effectively recorded and therefore were not suitably monitored to consider lessons learnt and reduce the risk to people. It was not possible to establish whether incidents should have been notified to Care Quality Commission (CQC) and the local safeguarding authority.

Care plans were not always up to date and did not therefore always contain accurate information about people's care and support needs.

The care and support provided to people was not always person-centred and did not always people's individual needs.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

Quality assurance systems were not effective and failed to ensure compliance with regulations. Where issues had been identified, the provider did not act in a timely manner to address these.

A high use of agency staff was in place. Areas of training needed to be improved.

The provider was working with local agencies due to the concerns raised by professionals who had visited the location.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 30 January 2020).

Why we inspected
This inspection was prompted in part due to a specific incident following which a person, using the service, died. This incident is subject to further investigation. As a result, this inspection did not examine the circumstances of the incident. In addition, we had received concerns regarding staffing and the management of the service including the maintaining of up to date records regarding people's care and support.

As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We did not review the remaining key questions. Ratings from the previous comprehensive inspection for those questions were used in calculating the overall rating at this inspection.

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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements.

Please see the safe, effective and well-led sections of this full report.

The overall rating for the service has remained as requires improvement.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe care and support of people, systems to recognise safeguarding, person-centred care and areas relating to leadership and the management of the service at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of

quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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

Haresbrook Park Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The first two days of this inspection were carried out by one inspector with another inspector assisting remotely on the first day. Two inspectors visited on the final day.

Service and service type
Haresbrook Park Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. They were not at work at the time of the inspection and were due to leave their employment with the provider in the near future.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We had some brief discussions with three people who used the service. Due to the Covid-19 pandemic no visitors were seen during the inspection. We did however speak with some relatives on the telephone. We spoke with eight members of staff. This included the manager, nominated individual, a consultant working for the provider to make improvements, a team leader, care staff and a domestic staff member. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with one visiting professional during the inspection. We spoke with seven relatives during the initial inspections.

We reviewed a range of records. This included people's care records and multiple medication records. We also looked at accident and incident records and a variety of documents relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at arrange of documents sent to us by management of the location throughout the inspection process. We carried out a final feedback session with the manager and deputy manager on Friday 13 November 2020 using an electronic facility.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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; Using medicines safely; Preventing and controlling infection

- People were at risk of avoidable harm. Risks to people had not always been identified by management and staff for corrective action to be taken in order to protect people.
- Fire safety measures was not always fully effective to ensure people, who were living at the home, were protected. On the first day of this inspection we found two fire doors which did not fully close into their rebate. On the final day of the inspection we found a door from the laundry propped open using a wedge. Another door into the laundry, although closed, had a door wedge close by. This meant in the event of a fire these defences against fire spreading would not have been totally effective in holding the fire back and therefore placing people at potential risk of harm.
- Risks to people in their own bedrooms were not suitably managed. Wardrobes were not always secured to the wall to prevent them accidentally toppling over. We found examples where chains had been removed from hooks in the wall behind the wardrobe. These risks had not been identified by staff at the home for corrective actions to be taken.
- Risks to people developing sore skin were not always managed. On the first day of this inspection one person, who was at risk of developing sore skin, was sat on a special cushion to help relieve pressure. However, the cushion was the wrong way around and therefore staff were not using this specialist piece of equipment in line with manufacturer's instructions. This was not noticed by staff who assisted the person with their breakfast and needed to be brought to the attention of the manager by the inspector. Not using specialist equipment correctly places people at unnecessary risk of developing sore skin.
- The provider failed to ensure medicines were consistently managed in a safe way, so they were administered to people as prescribed. This placed people at risk of not having their health care needs met.
- One person was prescribed a weekly patch to assist with pain management. We found evidence this had not always been applied as prescribed by the person's doctor over a period of seven weeks.
- There was conflicting recording regarding a person's medicine. We saw staff were signing for the medicine daily in line with instructions on the medication administration sheet showing the person was receiving the medicine. However, the person also had records of having the medicine only when needed and therefore indicating the person was not on the medicine regularly. The information was therefore unclear for staff members to ensure they were acting in line with the doctor's instructions.
- One person had four tablets left. We were assured by the team leader more would be delivered from the pharmacy and therefore the person would not run out. However, when this was checked with the pharmacy it became apparent no more were due. Therefore, the person would have run out of their medication had we not brought this finding to the attention of the management as internal systems had not highlighted the forthcoming shortfall.

● We saw gaps in medicine records whereby the provider could not demonstrate whether a person had received their medicines.
● Staff had signed to show people had received their medicine and then signed over the top of their original signature saying the person had declined the medicine.
● There was a lack of clarity regarding the use of creams and the recording of these. The directions were not always specified, and the provider was unable to demonstrate whether these items had been consistently applied to people's various limbs as prescribed by their doctor.
● Changes in people's medicines which were documented on the medicine records were not always supported within the care documents. This meant people's care documents did not consistently reflect when the change was made.
● Checks to ensure medicines were stored at a safe temperature were found to have not been routinely maintained. Having medicines stored at an incorrect temperature, outside of the manufacturers guidance, could have potentially resulted in the decomposition of the medicine.
● A sheet showing specimen signatures of staff able to administer medicines listed staff all of whom no longer worked for the provider. Staff involved in the administration of medicines at the time of the inspection were not listed. This meant it was not possible for management to reference initials used by the staff involved in the event of them having concerns regarding the recording of medicine administration to identify potential training requirements to safeguard people from errors.
● Staff were not always complying with guidance in relation to the use of face coverings during the Covid-19 pandemic.

The provider failed to ensure people were protected against the risk of harm and were keep safe. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our initial visits to the home we found certain aspects brought to the attention of management received attention and improvements were made.
● The initial shortfalls regarding fire doors were brought to the attention of maintenance staff and were found to have received suitable action when we returned to the home. The manager removed wedges we found on the final day of this inspection.
● As a result of our findings the nominated individual undertook to have a full audit of medicines carried out as well as investigate failings with the application of a person's patch. Queries regarding some of the issues raised regarding people's medicines were brought to the attention of the doctor to be resolved.
● Improvements took place regarding the taking of temperatures of people living at the home in relation to the monitoring of symptoms of Covid-19.
● The provider had purchased a thermal monitoring devise to monitor and record the temperature of staff and all persons entering the home.
● Equipment such as hoists for staff to use to assist moving people were serviced as required to ensure they were safe and maintained. Where repairs were recommended these had taken place.
● Temperature checks were carried out regarding hot water to reduce the risk of people sustaining scolding injuries.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider did not always have safe processes and systems in place to safeguard people, keep them safe and ensure they were protected from avoidable harm.
● The provider's systems for reviewing all accidents and incidents were not robust as management were not always aware of or informed of these incidents. We found incidents involving people had taken place or bruising identified which were not known to management. We found incidents of people having a fall

whereby no accident form was completed, no review of the incident had taken place and no investigation of incidents such as bruising were undertaken. As a result, these were not able to be included in the review system therefore management did not have accurate information to consider when learning lessons, so the same incident did not happen again.

● We made a safeguarding referral to the local authority in relation to our finding regarding a person not receiving their medicine as prescribed. This shortfall had not been identified by the management of the home.

The provider failed ensure systems and processes were in place to keep people safe from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were aware of their responsibility to report to management or other agencies such as the Care Quality Commission in the event of them witnessing abusive practices. Staff told us they had not witnessed any abusive practice we needed to be aware of.

Staffing and recruitment

● We have previously highlighted concerns regarding the high level of agency staff used by the provider and the providers ability to meet people's individual needs.

● Management were aware of the high number of male care staff in post and assured us they were making an effort to recruit female staff and be less reliant upon agency staff. Measures to recruit staff were in place and progress was being made.

Requires Improvement

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

- The provider was unable to fully evidence their ability to meet people's care and support needs.
- Care plans were not always an accurate reflection of people's needs so these were consistently met. For example, one care plan, although reviewed four days before our inspection, did not show in full a person's current medicines. This was despite the document stating, 'Care plan updated to reflect current needs.'
- Care records did not evidence aspects of how personal care needs were to be met such as shaving. Records did not evidence when staff had carried out this task or when the person refused. The provider was therefore unable to evidence how they were meeting the individual need of the person.
- Relatives we spoke with told us of their concerns regarding clothing going missing or about how their family member was at times inappropriately dressed considering the weather. One relative told us their family members clothes had, "Disappeared." Another relative told us, "It's very rare to see (person) in their own clothes". We saw a comment recorded in a communication book where staff had 'borrowed' clothing for one person from another. Both people were unable to consent to this.
- We saw some people had their bedroom personalised to reflect their own preference. Other rooms were however seen to be less personalised and contained basic furniture only. This observation was brought to the attention of the nominated individual and acknowledged.

The provider to ensure people received person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some improvements were noted to have taken place following our initial findings to improve the experience of people living at the home, especially people living with a dementia who required assistance with orientation. For example, the date displayed in the main dining room was incorrect. On 01 September 2020 the date shown was 02 August.
- The feedback from the staff team regarding their own observations of the care provided by their colleagues was positive. One member of staff told us they had found staff to be, "Caring." Another member of staff told us they enjoyed the work they were doing.
- The provider had with assistance from a local university introduced a person-centred programme designed to support people living with a dementia. The programme was designed to deliver a calm environment providing an unhurried approach using touch. The office manager spoke with enthusiasm about their plans to develop this approach. The newly appointed manager told us they wanted to formalise this further.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff were unable to tell us who had an authorised DoLS. As a result, staff were unable to be clear when they may or may not be depriving people of their liberty.
● Training records for staff employed directly by the provider showed staff had either not undertaken training in DoLS and MCA or the training was either overdue or about to become overdue. These timeframes were taking into account provider's own training plan and procedures.
● Records to demonstrate how permission was sought under best interests for people to undertake tests for Covid-19 from family members and others was not available at the time of the inspection. The previous manager forwarded to us a list of people and a family member indicating their agreement. The current manager was unable to provide any additional evidence regarding how decisions to undertake testing was reached. Following the final visit, the manager sent us a capacity assessment in relation to one person and the decision made for this person to have a Covid-19 test carried out. One relative told us they were not aware whether they family member had received a Covid-19 test or not.

The provider had failed to ensure people consent was obtained. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff told us they found the training and support provided to be good. Staff were able to tell us about the training they had undertaken either with the provider or via the agency they worked for. However, staff had not received all the training as identified as needed by the provider to ensure staff had the skills and knowledge to meet people's needs. The provider's own web site stated, 'Care staff specifically trained in dementia care, challenging behaviour and vulnerable adults.' We therefore found the statement regarding the training of staff to be incorrect. As part of the initial part of this inspection the nominated individual confirmed nine people living at the home displayed some form of challenging behaviour.
● The nominated individual informed us staff who were responsible for administering medicines had undertaken training via the agency through whom they were employed. Only one of these staff members had however had any competency observations undertaken.
● Staff told us they had undertaken training with a health care professional on the use of personal protective equipment used due to the Covid-19 pandemic.

Supporting people to eat and drink enough to maintain a balanced diet

● People were not always given the support they required to eat and drink although some improvements were seen during the inspection process.
● We brought our observations to the attention of the management team at the time of the initial inspection visits. They told us these were not the standards expected. However, on returning for the final visit some areas remained the same or similar, while other areas were improved.
● A board designed to show the choice of meals available to people was not used throughout the time we were at the home therefore not providing this information for people. We asked people prior to their lunch what they were going to have. People were not aware of what the choice was going to be. The current manager told us they intend to have pictorial menus available on each table for people to refer to and select from. Condiments were not routinely offered to people and were not readily available.
● Staff were seen taking some people's midday meal to them on a tray. We saw people were taken their sweet at the same time as the main meal. This meant the sweet would not be as warm as when served when people came to eat it. This practice was seen on each occasion.
● We saw an improvement in the support people received while in the dining room to assist them with eating and drinking. This resulted in people eating more of their meal and not pushing it away.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's healthcare needs were not always recorded to evidence discussions we were informed had taken place. This was a potential risk to people as staff did not have consistent information available to them regarding people's individual health needs.
● During the inspection we were told by the nurse in charge a discussion had taken place with a visiting healthcare professional regarding discontinuing a person's medicine. No record existed of this discussion and the healthcare professional had no recollection of any such discussion having taken place. Therefore, the provider could not evidence the reason why a medicine was stopped.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The provider has been rated as requires improvement or inadequate for six consecutive inspections. The provider was last rated as good in our report published April 2016.

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

- There were a range of changes in the management arrangements during the period of this inspection. The registered manager was not working at the home during the first two days of the inspection and had deregistered by the time of our final visit. An interim manager was in place however they were no longer working for the provider at the time of our final visit. On our final visit a further manager was in place who was planning on applying to the Care Quality Commission [CQC] for registration. Management support was provided by the nominated individual and a consultant working for the provider. Both these persons were no longer working for the provider at the time of our final visit. The provider had resumed the responsibilities of nominated individual.
- Quality assurance processes had not been robust and continued to need improvement. They did not identify the concerns we found throughout the inspection placing people at potential risk.
- Medicine audits were completed by a senior and signed off by the manager and nominated individual however these had not identified shortfalls. A report carried out on behalf of the provider stated there were no issues identified regarding medicines. These audits and checks were not effective as they had not identified the shortfalls identified during the inspection.
- Temperature records had not been completed to evidence medicines were stored at the correct temperature. Fridge and room temperatures were recorded twice throughout the whole of July 2020. In August the fridge temperature was recorded ten times while the room temperature was not taken at all. A medicine audit had not identified this lack of monitoring. The provider had on display instructions stating, 'Storage temperatures of medicines rooms and fridges are recorded daily and any deviation from the required range must be acted upon immediately by staff.'
- The recording of some incidents and accidents were not reported to management and therefore not accounted for in the audits undertaken. Systems in place had not identified this shortfall. This meant the management information was incorrect and not an accurate reflection of the accidents and incidents within the home. Once brought to the attention of the management in place at the time there was no evidence the shortfall was acted upon to ensure these incidents were subsequently reviewed.
- During the initial days of the inspection the management team told us they were aware of the need to make improvements to people's care plans. We were assured this was in hand and taking place. However,

when we assessed care plans which showed as having been recently reviewed, we found significant shortfalls whereby they did not reflect people's care and support needs. These plans did not provide accurate information for staff to follow in terms of consistent care to meet people's individual needs. Further assurances were given to drive improvement in care planning at the end of this inspection.
● Details upon the provider's own web site regarding the training provided to care staff were found to be incorrect and misleading regarding the training staff had undertaken.
● Systems to identify environmental risks were insufficient to ensure people were kept safe. During the inspection we found fire doors which did not close correctly. In addition, there was evidence of fire doors propped open and wardrobes not secured to the wall to prevent accidental toppling and potential injury.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We initially found the provider had not adhered to their own policies and procedures in relation to infection control and the management of Covid-19. For example, a procedure stated people living at the home were to have their temperatures taken twice daily and staff to record their temperature at the start of their shift. We found failures in both and neither had been identified by the management. Improvement had been made by the time this inspection was concluded.
● Although the new manager had introduced new systems and practices within the home these needed further improvement and time to become established and embedded.

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
● Some relatives we spoke with at the time of our initial visits raised concerns regarding the management of the home. One family member made mention of the frequent changes. Others spoke about management lacking knowledge of their family member and people's individual care needs.
● Relatives were spoke with were not always happy with the communication which had taken place during the Covid-19 pandemic in relation to their family member and the management arrangements.
● The registered provider is legally required to inform people of the current CQC rating of the service. This was displayed within the home environment as well as on the provider's web site.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● This inspection was undertaken during the Covid-19 pandemic. This therefore had reduced opportunities for people living at the home to be engaged not only with the wider community but also with family and friends.
● One relative confirmed they had managed to visit their family member in the garden. At the time of our final visit the manager was looking at opportunities available to them to enable relatives to see their loved ones in a Covid-19 secure way.
● The new manager had introduced a daily 'briefing' involving all members of staff. This was introduced to improve communication and the standard of care and support provided.

Working in partnership with others
● At the time of our final visit to the location the manager in post was keen to work alongside the local authority and the CQC. The manager was aware of concerns expressed by professionals and acknowledged the need to drive forward improvements.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failure to undertake best interests decision with appropriate persons where people were unable to give their consent to a procedure taking place. Regulation 9 (1) (a),(b),(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to provide person centre care to people living at the Haresbrook Park. 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 The provider failed to ensure people received care and support in a safe way. Regulation 12 (1), (2) (a), (b) (d), (f), (g),(h).

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 provider failed to ensure systems and processes where in place to protect people from the risk of abuse.

Regulation 13 (1), (2), (3)