# Banstead, Carshalton And District Housing Society

# Roseland

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Roseland is a residential care home providing support for up to 39 older people. The service provides support to people who have frailty, disabilities and may be living with dementia. At the time of our inspection there were 24 people using the service.

People's experience of using this service and what we found
The management of risks to people were unsafe which included people's nutrition, hydration, health, and mobility risks. People did not all have fire evacuation plans in place and the environment was not always safe for people. People were having frequent incidents and accidents and insufficient steps were being taken to mitigate these risks. People's medicines were not being managed in a safe way which put people at risk of harm.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider failed to ensure that safeguarding concerns were investigated and reported appropriately. There were not sufficient staff to support people at the service. The recruitment of staff was not robust.

There was a lack of provider oversight of care at the service. The provider failed to have a registered manager in place which is a requirement of their registration. Audits were not effective in identifying shortfalls. Staff did not always feel valued or listened to.

There were people who felt they were safe with staff. People, relatives and staff fed back positively about the manager at the service.

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 December 2023)

Why we inspected
We received concerns in relation to the management of risks associated with people's care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

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

Enforcement and Recommendations
We have identified breaches in relation to the unsafe management of risks to people, poor management of medicines, safeguarding concerns not being investigated and reported, deployment of staff not being effective and poor leadership and oversight.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Details are in our safe findings below.

### Is the service well-led?

**Inadequate**

The service was not well led.

Details are in our well led findings below.

# Roseland

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection was carried out by 3 inspectors.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. However, there was a manager at the service who supported us with the inspection. They had not submitted an application to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well

and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and requested information from the provider in relation to accidents and incidents.

We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service, 3 relatives and 1 visitor about their experience of the care provided. We also observed interactions between staff and a number of other people who used the service. We spoke with 10 members of staff including the manager, senior carers, care workers, chef, and housekeeping staff. We spoke with 2 visiting professionals.

We reviewed a range of records. This included 6 people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

# Is the service safe?

## Our findings

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

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

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

At our last inspection in October 2022 the provider had failed to ensure risks to people's safety were robustly assessed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risks associated with people's care were not managed in a safe way. There were people at the service who had been assessed to be at high risk of malnutrition. The manager told us, and their care plans confirmed there were two people who had lost weight and needed to be weighed weekly. Their food and fluid intake were to be recorded daily. When we checked their weight charts staff were only weighing them monthly. This was despite one person losing 3 kilograms between their recorded weights in February and March 2023.
● The food and fluid charts were not always completed, and we saw gaps between days. When they were completed, there were frequent gaps through the day where staff were not recording whether the person had been offered a snack or a meal. Staff were not always recording the food portion sizes and where people had not had their target fluids there was no record of how this was followed up. A member of staff told us, "Documents don't always get filled in, we are so busy." This put people at risk of further malnutrition and dehydration.
● The risks associated with people's skin integrity were not being managed in a safe way which placed people at risk of developing pressure wounds. The manager told us one person had developed a pressure wound. Their care plan had not been updated in relation to this risk stating, "(Person's) skin is fully intact." There was no guidance in place for staff on how frequently staff needed to reposition the person in bed. Although the person had a pressure mattress, the person had not been weighed so staff could not be assured the setting was appropriate. This meant the effectiveness of preventing pressure sores could be reduced.
● Where people had behaviours of high anxiety there were no risk assessments or guidance in place for staff on best to support them with this. For example, the manager told us one person showed anxiety when they were offered personal care by staff. There was no risk assessment or strategies in the person's care to guide staff on how best to support the person.
● At the previous inspection Personal Emergency Evacuation Plans (PEEP) were not always in place to inform staff and emergency services how best to support people in the event of a fire. At this inspection this had not improved. Of the 24 people living at the service there were 9 people that had no PEEP in place. The manager told us, "I have taken out the old ones to update them." They had not considered that if there had been an emergency in the meantime people may not be appropriately supported if there had been an

emergency.
● Environmental risks had not always been well managed. For example, there were a large number of people that used frames to assist with walking. The carpet on the upstairs landing (where people accessed) was buckled which compromised people being able to walk over it safely. The manager told us, "The maintenance is concentrating on the downstairs and the walls." Where people had bed rails there were not always assessments in place to determine whether there was a risk of entrapment.
● There was a risk that staff would not be alerted when people used their call bell. On the day of the inspection the alarm in the front office was beeping for nearly ten minutes before we alerted staff. A member of staff told us, "The sound can be heard in some of the corridors but if staff are in the lounge, then it can't be heard." The manager told us they had requested pagers for staff as previous ones had broken however, steps had not been taken to mitigate this risk in the meantime.
● There were elements to the infection prevention and control that were not good and put people at risk. The sluice room downstairs had been left open, the cleaned commode bowls had been piled up onto the bin and the sink was stained and dirty. The upstairs sluice door had been left open and there was a commode bowl left on the sink with faeces stains in it. The manager told us of the commode bowls, "I did tell them (the provider) we need rails to store them and to change the sinks." However, nothing had been done to manage this in the interim.
● The large jugs on the tea trolley used for milk had brown stains on it. The water jugs in people's rooms had a substance left from stickers on the lids which affected effective cleaning.
● There was a lack of robust management around accidents and to minimise risks to people's safety. We noted from the provider's falls report and incident reports there were people who had fallen on numerous occasions. For example, one person had fallen at least 13 times since December 2022. There was no evidence the person had been referred to the falls clinic to reduce the risk to the person.
● Incidents were not always being recorded to determine what happened and actions taken as a result. For example, the manager told us about recent incidents of behaviour of two people at the service. Another incident with a person where emergency services had to be called and an incident of injury to a fourth person. None of these were recorded on incidents forms.
● Incidents and accidents were not analysed appropriately to look for trends and themes. Prior to the inspection we asked the manager to send us an analysis of all accidents and incidents. Although we were sent information related to falls there was no analysis undertaken to determine whether there was a possible cause for example staff deployment.

The failure to ensure risks to people's safety were robustly assessed was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.
● We did see staff safely supporting people to move from their wheelchairs to lounge seats. One relative told us, "There's always somebody with her. It's managed very well."

Using medicines safely

At our last inspection in October 2022 the provider had failed to ensure the management of medicines was undertaken in a safe way. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. No improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The management of medicines was not safe and put people at risk. At the previous inspection people's topical Medicine Administration Records (MAR) charts, which guided staff to where prescribed creams should be applied, were not completed consistently. We found this was still the case on this inspection. On one person's MAR between 23 December 2022 and 03 March 2023 there were over 28 days where it was not recorded whether the person had their cream applied. This meant staff could not confirm whether people were receiving the right support with topical creams on a daily basis.
● People's medicines were not always kept in its original packaging. Each person had their own basket with their medicines in. We found two people's medicines had been removed from their original packaging as staff told us the boxes were too large. This was not in line with the provider's policy that stated, "All medication is stored in its original packaging and is held securely in the medication cabinet…" This meant there was a risk the medicine may be given to the wrong person as there was no labelling on the strips that were taken out.
● The majority of MARs we reviewed were not completed in line with NICE 'Managing Medicines in Care Homes' guidance. People's MAR had not been signed or counter-signed by staff to confirm their accuracy. This was also not in line with the provider's policy. This meant there was a risk people would receive medicine that was not intended for them.
● There were no stock levels recorded on the MAR and it was therefore not always clear what the stock should be. Although stocks were recorded elsewhere there was a risk that they may run out of medicine for a person before they had an opportunity to order further stock.
● Where staff were required to check a person's heart rate before they administered a medicine this was not always being done. We saw from one MAR there were five occasions in March 2023 where a person's heart rate had not been recorded despite there being a form in place for this information to be added. This put the person at risk of being administered a medicine where it may not be safe to do so.
● Where people had 'as and when' medicines there were not always protocols in place to guide staff on when the medicine should be offered to the person.
● People had prescriptions of steroid creams that were not intended for long term use as they can thin the skin. There was information missing on the MAR on how long the creams needed to be applied for. There was also a lack of information on where the cream needed to be applied.
● There were people that had diabetes and required their blood sugar levels to be checked by staff. However, this was not being consistently checked by staff. One person's care note stated their levels needed to be checked twice a day however, there had been no checks undertaken since 28 February 2023. This person has been admitted to hospital just prior to the inspection due to complications with their diabetes. The manager told us of this, "Nobody has told me they have not been taking it (blood sugar checks)."
● There was no formal assessment of staff competency to administer medicine to ensure this was being done safely and in line with the provider's policies.

The failure to ensure risks to people's medicines were managed in a safe way was a repeated breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is

usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA and if needed, appropriate legal authorisations were not in place to deprive a person of their liberty.
● Where decisions were being made for people, there was not always evidence their capacity had been assessed. For example, one person was under constant supervision from a member of staff. There was no assessment of the person's capacity to agree to this restriction to determine this was in the person's best interests' or whether less restrictive measures had been considered. A member of staff told us of this person, "[Person] loves to wander but can get aggressive and doesn't like someone ebbing [them] all the time."
● Where other restrictions were in place for people there were either no capacity assessments in place or the assessments were incomplete. One person had a sensor mat, their capacity assessment was not completed in relation to whether the person was able to understand, retain, weigh up or communication about the restriction.
● Another person had no consent forms in place to be living at the service. The manager told us the person did not want to be at the service, yet there had been no assessments in relation to whether the person had the capacity to make this decision.
● There were people who had their medicines covertly (when medicines are administered in a disguised format). There were no capacity assessments in place or best interest decision to determine whether this an appropriate restriction or whether other alternative ways of giving the medicine had been considered.

The failure to ensure the principles of the Mental Capacity Act 2005 were consistently followed was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● We asked people whether they felt there were enough staff. One person told us, "There's not always someone around. They're all quite rushed."
● The provider failed to ensure staff were deployed effectively which put people at risk of harm. On the morning of the inspection there were people that were being cared for in bed on the top floor. We noted there were no care staff present on the top floor for over 30 minutes and one person in bed was unable to use their call bell to alert staff if they needed anything.
● The manager told us during the day there were four carers and a senior on duty each day. They told us the senior undertook the medicine round and managed the floor. However, the manager confirmed they recently had to provide one to one support for a person but had not increased their staff levels as a result. The manager told us, "I wish I could increase it by another one (staff)."
● At night there were four carers on duty. We noted from the incident and accidents report there were frequent unwitnessed falls at night when people were in their rooms. According to the records there had been 11 unwitnessed falls during the night shift between January and 13 March 2023, five of which had resulted in an injury. One member of staff told us, "People are higher risk of falls in their room. They will be in their room and on their own." We saw from the minutes of a meeting with staff in January it was recorded, "Lots of falls at night, need to be more vigilant and use the check charts." Despite this known risk steps had not been taken to mitigate this and falls were still occurring.
● Staff fed back concerns about staff levels and the impact this had on people. One told us, "Not enough, we are struggling big time. We didn't get a break yesterday. People are not getting full care, they are being skipped, not being washed." Another told us, "Not enough staff. We have (person) who is one to one and someone has to be with (person). The senior isn't on the floor to help us, they will be doing meds and running the floor."

The failure to ensure there were appropriate levels of staff deployed at the service was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider did not operate safe recruitment practices when employing new staff. We reviewed three files of staff that had been recruited since the last inspection. There were elements of information missing from each one.
● One had no application form completed, no photo ID or proof of address and no evidence of criminal record check. Whilst another did not have a full employment history completed and only one reference despite the service policy stating they required two. On a third, the rights for the member of staff to work at the expired in April 2022 with no evidence the provider was assured the member of staff was still able to work at the service.

The provider failed to undertake robust recruitment practices which is a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse and neglect. The manager and staff had received safeguarding training, however they were not always recognising or investigating incidents of alleged abuse. We noted from an incident report one person was found with a skin tear to their wrist. The person was unable to tell staff how this occurred, it was recorded as assumed it may have been the person's watch that caused the injury. There was no evidence of any investigation into whether this could have been caused in any other way.
● On another occasion we saw from an incident form a person was found to have a significant hip injury which the person was at risk off. The person was unable to say how this occurred and no investigation was undertaken by the provider to determine the cause of the injury. The incident report concluded the person caused this injury with their own poor moving and handling however there was no evidence on how this had been determined.
● The provider failed to report all safeguarding incidents to the local authority safeguarding teams in line with legal requirements. We saw from the falls reports there had been 20 unwitnessed falls since 1 January 2023 with 7 injuries. The local authority confirmed with us that none of these incidents had been reported to them as required.

Failure to investigate and report instances of alleged abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People fed back they felt safe with staff. One told us, "Yes, I feel safe. The carers are all nice." From our observations people looked relaxed at and ease with the staff. One relative told us, "From what I've seen, she's safe here."

Visiting in care homes
The provider was facilitating visits for people living in the service in accordance with the current guidance. One relative told us, "There are no restrictions at all. All the family are around."

Inadequate

# Is the service well-led?

## Our findings

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

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

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

At our last inspection in October 2022 the provider had failed to robust oversight of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- At the last inspection in October 2022 we identified breaches of regulation around risks to people not being managed safely and the lack of robust oversight by the leadership team. We required the provider to send us an action plan to show how this was going to be addressed. However, the action plan did not have any information on how they intended to meet the breach around the lack of oversight.
- It is a requirement of the providers registration to have a registered manager. We have not received an application for a registered manager since June 2022.
- Internal quality assurance systems and processes to audit or review service performance and the safety and quality of care were not operating effectively. There were a lack of audits undertaken by staff at all levels within the provider's organisation. These could have identified or prevented issues occurring or continuing at the service. The manager told us, "There is so much paperwork that could be done if there were more than one pair of hands. There is so much to do, and I can't do it all on my own."
- The manager told us daily meetings took place with the heads of departments. The heads of departments were then to disseminate this information to all staff. However, on review of the minutes the meetings were not always taking place. Between 1 March 2023 and 14 March 2023 only 4 meetings took place.
- Prior to the inspection the provider sent us an analysis of incidents and accidents. Although they recognised actions needed to be taken to reduce risks associated with falls and incidents, we found no evidence work had been started on this.
- Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. We identified through incident and accidents reports there were incidents where people had sustained injuries. These at the time had not been notified to us by the provider.

The failure to ensure robust and effective quality assurance systems were in place was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was positive feedback on the manager at the service from people, relatives and staff. Comments included, "Manager seems very, good", "(Manager) is proactive and knowledgeable. She always responds to queries", (Manager) has time for you" and, "I can't fault (manager). She listens to anything. She listens to all problem. She will speak to me if there is a problem."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had not a set of values they expected staff to embody when supporting people. The manager told us improvements were needed around the culture within the service. This was reflected in the lack of organisation at the service where senior staff were not aware of their responsibility around the oversight of care and care records.

● We were made aware of an incident where the provider had offered a bonus to the first member of staff who could encourage a person to have personal care. This did not promote a positive culture where people were seen as individuals, nor did it promote personalised care for the person.

● There was a lack of provider presence at Roseland, and we received mixed feedback from the staff we spoke with about the culture and morale at the service. One member of staff told us, "(Nominated Individual) comes in and just sits in that room. He doesn't even acknowledge us sometimes." Another told us, "Higher up, I don't think we get the support. I had to email (senior management) about a problem. I've not even had an acknowledgment."

● Although a residents' meeting had taken place in January 2023, this was not used as an opportunity to discuss areas people would like improved. Instead, people were just asked if they wanted to raise concerns. Where one person did raise a concern, it was not clear from the minutes whether this had been addressed. The meeting could have been used as an opportunity to prompt feedback on what activities they would like and what they would like on the menu.

● There was also reference to people being asked to approach the heads of departments about concerns rather than approaching the manager.

● People, relatives and staff were not asked to complete surveys to gain their view of the service to drive improvements. One member of staff said, "We don't get asked to fill in a survey, I think it's important to feedback."

The provider failed to ensure the service performance was evaluated and improved is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

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; Working in partnership with others

● The provider and manager had not always ensured they had shared information externally regarding unsafe care and service users being harmed to ensure there was an adequately informed review, investigation and actions agreed to help avoid or prevent these issues happening again.

● Staff had not ensured that all actions and recommendations identified by health and social care professionals to ensure people achieved good outcomes were communicated to and understood by all staff. For example, an external dietician had provided guidance in relation to supporting a person gain weight including offering the person fingers foods. The chef was not aware of this guidance, and we did not see the person being offered finger foods. A member of staff told us, "Eating is hit and miss (for the person). I didn't know she had seen a dietician. That would be useful to know."

The failure to ensure the service worked in partnership effectively with other agencies is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●Some healthcare professionals told us staff were good at contacting them for advice and had worked well with them. One professional told us, "They're very proactive. It's one of my best homes. They're very welcoming. They have care at the forefront of everything. They know the patients well."

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure the principles of the Mental Capacity Act 2005 were consistently followed. |

**The enforcement action we took:**

We have cancelled the providers registration.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to ensure risks to people's safety were robustly assessed and people's medicine were managed in a safe. |

**The enforcement action we took:**

We have cancelled the providers registration.

| 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<br><br>The provider failed to investigate and report instances of alleged abuse. |

**The enforcement action we took:**

We have cancelled the providers registration.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to ensure robust and effective quality assurance systems were in place. |

**The enforcement action we took:**

We have cancelled the providers registration.

| Regulated activity | Regulation |
| --- | --- |

| | |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider failed to undertake robust recruitment practices. |

**The enforcement action we took:**

We have cancelled the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure there were appropriate levels of staff deployed at the service. |

**The enforcement action we took:**

We have cancelled the providers registration.