Mrs Christine Lyte

Caythorpe Residential Home

Inspection report

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Caythorpe
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 3 May 2017 and was unannounced.

The home provides residential care for up to 14 older people some of whom may be living with a dementia. Fourteen people were living at the home on the day of our inspection.

The home was owned by an individual person and they were also the registered manager for the home. We have referred to this person as the provider throughout the report. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

The provider was not meeting the legal requirements in two areas of care provided. They had failed to ensure that the correct checks were completed to ensure staff were safe to work with people living at the home. They had failed to ensure that the systems to monitor the quality and safety of care were effective. You can see the actions we have asked the provider to take at the back of this report.

There were enough staff in place to care for the people living at the home. Staff received training when they first started working at the home to ensure that they had the skills needed to provide safe care for people. However, the frequency of training to refresh and update their skills did not support staff to be up to date with current best practice.

Where people had been unable to make the decision to live at the home the provider had submitted appropriate applications for assessment under the Deprivation of Liberty Safeguards. However, it was not always clear who was legally entitled to make decisions for people and if decisions had been made in people's best interests.

Most staff were kind and caring and there was a pleasant relaxed atmosphere in the home. Although people did raise concerns about an individual member of staff who could be more abrupt. People's dignity was not fully respected in the care they received and people's independence was at times restricted by their care.

Medicines were safely stored and staff administered the medicines in a safe methodical manner to reduce the risk of errors. However, one person had not received some pain medicine due to a lack of clarity on how it should be administered. In addition, it was not clearly recorded why people had been offered medicines prescribed to be taken only when needed.

People were happy with the quality of food available to them and were supported to maintain a healthy weight. People were offered a choice of hot and cold drinks throughout the day to ensure they stayed hydrated.

Care plans recorded the risks to people while receiving care and provided information to support staff to provide safe care. However, they did not contain enough information to support staff to personalise the care to people's individual needs. People were supported to access activities which helped them to stay mobile and to engage with and access the local community.

People were happy to raise complaints or concerns with the provider and were confident they would be resolved. Systems in place to monitor the quality of care provided were not always effective and did not support the provider to drive improvements in the care people received.

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 consistently safe.

The provider did not complete the required checks to ensure people were safe to work with people living at the home.

Risks to people were identified and care put in place to support people to receive safe care. However, some environmental risks had not been identified.

Staff had received training in keeping people safe from abuse. People felt safe living at the home, but raised concerns about other people accessing their bedrooms.

The home was clean and tidy but systems to reduce the risk of cross infection were not always managed.

People's medicines were stored and given to people safely. However, one person was not supported to access their medicine due to a lack of clarity about the administration

Is the service effective?

Requires Improvement

The service was not consistently effective.

Where needed DoLS applications had been submitted for people. However, it was not always clear in people's care plans who had the authority to make decisions for them

Staff received training when they first started to work at the home. However, there were long gaps between some refresher training for established staff.

People were happy with the quality of food their received and were supported to maintain a healthy weight.

People were supported to access healthcare professionals when needed. However, advice about care was not always immediately actioned.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us most staff were kind and caring but raised concerns that one member of staff could be abrupt at time.

Staff had received training in supporting people's dignity, but people told us that they did not always provide care which respected their dignity. .

Staff and the environment did not always support people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had been involved in planning their care and care plans contained information staff needed to provide safe care. However, they did not support people to received person centred care.

People were supported with activities which kept them entertained and supported them to access the community.

People knew how to complain and were happy to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to monitor the quality of care that people received were not fully effective.

People's views of the quality of care they received were gathered.

The provider was approachable and people living at the home, their relatives and staff were able to raise any concerns with them.

Caythorpe 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 care, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 3 May 2017 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke with five people who lived at the home, three visitors to the home and spent time observing care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with a senior care worker, two care workers, the activities co-ordinator and the provider.

We looked at five care plans and other records which recorded the care people received. In addition, we examined records relating to how the home was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

The provider had systems in place to check if staff had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the provider had completed structured interviews. However, the provider had only completed basic disclosure and baring service checks on new staff instead of the enhanced check required by our regulations. This meant that they had not searched for any cautions, warnings, reprimands or spent convictions or searched the adult or children's barred lists to check that the applicant was suitable to work with people living at the home.

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

The provider told us they had a staffing tool in place that would estimate how many care staff were needed to support people safely and in a timely fashion. In addition, the provider explained how they would look assess which people needed increased levels of care. For example, if more people needed to be cared for in bed. They would also work on a few shifts to monitor staff's workload. These systems supported the provider to be flexible with their staffing levels and have more staff on shift when needed.

People told us that they felt safe in the home and that the home was a safe environment for their family members. Relatives also told us that they were happy their family members were safe. One family member said, "One thing we do like is it is secure." However, while people did say that they felt safe they raised concerns that people living with dementia would occasionally try and get in their room. A relative said, "People keep going into her room, one man walked in while she was washing. She would like a stair gate in place to help keep her in private." Following our inspection the provider wrote to us and told us they had ensured a stair gate was put in place to help maintain the person's privacy.

Several people raised concerns regarding the reliability and positioning of the call system in bedrooms, especially at night time. One person told us, "I have a lot of trouble with the alarm, it doesn't always work, but when it does they come quickly, it gets pulled out and won't work. I tried to get out of bed one night and I got one foot wrapped round it". We found that the lead for the call bell had to be stretched across the doorway and along the bed side presenting a trip hazard to anyone entering or leaving the room and indeed getting into and out of bed. Additionally it was likely that it could easily be accidently pulled out of its socket.

Staff had received training in how to recognise when people may be at risk of abuse and what actions they needed to take to help people stay safe. Staff were clear on how to raise concerns about abuse both to the provider and to relevant external agencies.

The home was in an old and characterful building. This meant that there were risks with changes in floor levels and uneven floors. The provider had recognised these risks and had ensured that there were appropriate hand rails and warnings in place to keep people safe. However, some issues had not been identified. People were not fully protected from the risk of burning themselves on a hot radiator as some

radiator covers were not fixed to the walls. In addition, the hot water in two bedrooms and a bathroom was hot enough to scald a person. We raised this with the provider and they told us they would ensure temperature valves were fitted to keep people safe.

There were fire risk assessments in place for all the people living at the home to support emergency services staff if they needed to help people evacuate the building. In addition, there was a business continuity plan in place to ensure that people had a safe place to take shelter if they could not remain at the home.

Risks had been identified and care was planned to reduce the risk of people experiencing harm. For example, risk assessments had been completed around people's likelihood of developing pressure ulcers. Appropriate equipment was in place to reduce the risk of occurrence. In addition, people's mobility had been assessed and the equipment and support they needed to safely move around the home was recorded. Accidents and incidents were recorded and appropriate action had been taken.

However, we saw two moving and handling incidents which concerned us. We raised our concerns about these with staff. They told us that one of the people could be a bit unpredictable and they could not use a frame because one of their arms was poorly. However, no other equipment was available to support the person to move safely. For the other person staff had not followed the person's care plan and the provider told us they would raise this with the member of staff.

We observed a medicines round and the member of staff administered the medicines in a safe manner. They stayed with the person to ensure they took their medicines safely and did not require any assistance. People were offered the opportunity to take medicines such as painkillers that were prescribed for them but which they may not need all the time and there were protocols in place to support staff to administer these medicines consistently. Medicines which needed to be kept cool were in a separate medicines refrigerator in the kitchen. However, the refrigerator was not locked and so these medicines were not secure.

One person was prescribed a medicine to help them manage their emotions. This had been prescribed to be taken as and when it was needed up to three times a day. However, records showed that it had been given daily and there was no record of who had made the decision to administer the medicine and why. In addition, the records did not accurately record the time of the administration.

We saw one person was at the home to regain some strength before returning to their own home. This person was in pain and was struggling to walk. Record showed that they had not received all of the pain medicine available to them as their discharge information from the hospital had lacked clarity. Staff had not contacted healthcare professionals to gather further information on how this medicine should be administered. Consequently this person had been in pain and had been restricted in their movement for a week.

We raised these concerns with the provider who took immediate action to discuss the pain relief available with the doctor and get some advice on administration. Following our inspection the provider wrote to us and told us they had put a system in place to ensure that medicines were checked when people moved into the home to stop this happening in the future.

People told us that they felt the home was clean. One visiting relative told us, "It always smells lovely." There was an odour of urine in one person's room. Their relative told us, "The room he's in does smell a bit of wee. I'd hope they'd clean it more now he's here full time." We discussed this with the provider who acknowledged this was an issue and stated the carpet was cleaned regularly but would be done again immediately.

In a number of toilets, bathrooms and bedrooms there was no hand wash available for people to wash their hands. In one person's bedroom there was a reminder for staff to use antibacterial hand wash but there was none available. We identified other infection control concerns around the home. For example, some of the wheels on the dining room chair were rusty, and some of the dining room table legs were also rusty. This meant it was not possible to clean them effectively. The cleaner had a set routine for each bedroom which included cleaning the toilets. However, they did not use the appropriate coloured cloth for cleaning the toilet and this meant there was an increased risk of cross infection. We discussed our concern with the cleaner who said they had run out of the appropriate cloths. However, we later saw they had fetched some of the correct cloths from the storage cupboard.

The infection control audits had been completed in April 2017 and actions had been identified for the staff to check that there was protective equipment available and hand wash available in people's rooms. From our findings we could see this action had not been taken. Following our inspection the local authority infection control lead visited the home to offer guidance and support. They told us that the home was clean but more attention needed to be given to the monitoring systems in place.

Requires Improvement

Is the service effective?

Our findings

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Three people living at the home had had their DoLS authorised. One more person was currently being assessed to identify if they needed restrictions on their liberty. No one had any conditions placed on their DoLS

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.

It was not always clear in people's care plans if family members had the legal authority to make decisions for people. In addition it was not always clear that decisions had been made in people's best interests. For example, one person had also had the lock on their door removed for safety reasons. However, there was no record that this had been part of a best interest decision to show why the restrictions to the person's privacy were proportional to the need to keep them safe. In addition, where people needed bed rails or belts in shower chairs to keep them safe no assessment had been completed to see if this was in their best interest.

This was a breach of regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent.

There was a structured induction in place for staff when they started to work at the home. This consisted of shifts where they shadowed an experienced member of staff and training to ensure staff had all the skills needed to care for people safely. Staff told us the training included information on how to move people safely and how to keep people safe from the risk of cross infection. Staff who had not worked in a caring role prior to starting at the home were supported to complete the care certificate. The care certificate is a set of national standards which provide staff with the skills needed to care for people safely.

Other staff told us that they had received refresher training in a number of subjects and there was a training plan in place which allowed the provider to monitor when people needed further training. However, it showed that staff training was not up to date. For example, some staff had not received training in how to keep people safe from abuse for six years and eight members of staff had no recent infection control training

Staff told us that they had received regular supervisions. In addition, to regular supervisions staff had told us that they were able to speak to the provider on a daily basis to raise any concerns

People told us that they felt the food at the home was good. One person said, "We've got a wonderful cook." A relative told us, "The food's lovely, they cook nice things and it smells like home." People were advised of the day's menu and asked for their choices during the morning. The person preparing meals on the day of the visit told us, "Their choice is given in the morning. We'll always find an alternative if there's anything they don't like or particularly want." A relative who told us her family member had diabetes said, "They do offer her alternative meals if they're worried about sugar content, like today they are giving her fish instead of the sweet and sour."

People's nutritional risk was assessed. We saw that one person has been identified as being at risk nutritionally and had been referred to the GP who had prescribed nutritional supplements. However, the person had refused to take them. Staff continued to monitor the person's weight to ensure that they were able to maintain their current weight.

At lunchtime some people were assisting others with their meals in ways which could have a detrimental effect on hygiene or infection control. In one case we saw a person picking up food dropped on the table and lap by another using their fingers and placing it back on the person's plate and in another we saw a person using her own cutlery whilst assisting another with her meal. Staff did not appear to be aware of this.

People were given the right adaptive equipment they needed at mealtimes in order to eat independently. For example, one person was given a plate guard to enable him to eat his lunch. Where people needed support to eat and drink care workers were encouraging and took their time to ensure the person had enough.

People told us they got enough to drink. One person said, "We get plenty of tea and coffee, with breakfast, one at 11am, then lunchtime and there'll be another soon." People had access to cold drinks through the day and were offered a choice of drinks with their meals.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed.

However, people had mixed views on their ability to access healthcare. One person told us, "The doctor seems to come quite quickly when they've called him. They tell us straight away." People also raised concerns that it had been too long since they had seen the chiropodist. One person said to us, "Only thing is the woman that does the toes hasn't been here for eight weeks and they need doing." A relative told us that their family member needed to see a chiropodist.

In addition, their appeared to have been a breakdown in the communication with the community nurses who visited the home. The community nurses arranged to come back the next day to provide the care for this person. Also healthcare professionals raised concerns that at times senior care staff were not always up to date with people's needs. In addition, where they had made plans for people to receive care on certain days those people were not always ready. We saw this on the day of our visit when they nurses had visited to dress two people's legs but were unable to provide care for one person had they had not had a bath and needed one before their legs could be attended to.

Requires Improvement

Is the service caring?

Our findings

All the interactions we saw between staff and people living at the home were positive, often with physical closeness, such as hugs and hand holding, and praise and encouragement being given. We saw examples of where staff took time to respond to people and offer reassurance where required. We saw that staff spoke to people in a kindly manner. One person told us, "Staff are nice; they look after me very well." Another person said of her care "It's very good, no complaints at all really. The food is good; I've a clean and comfortable room. We have a good laugh and a joke and a giggle."

Staff provided care for people in a calm reassuring manner. An example of this was a person who was assisted into the dining room by a member of staff and supported to move to a chair. The member of staff did this in a patient, kindly manner and constantly offered encouragement and praise to the person. Staff also brought another person in a wheelchair; we saw the carer took time to ensure the person was comfortable before leaving her.

However, several people we spoke with raised concerns about a particular member of staff who was more abrupt with them. One person told us she felt that a member of staff was "a bit bullying, she's made a person cry. She's horrible with [person], throws her in the chair." Another person said in regard to the same member of staff, "It's things that needn't be, she is always a bit bossy, speaks to you like a child and when you're 80 you don't want that." They added, "She's always a bit like that with me. I've said I know you don't like me. She said it's because I won't do as I'm told, said it like I'm a little kid."

Staff told us they had received privacy and dignity training and would take actions to ensure people's dignity was maintained. For example, they would ensure that they could see health professionals in a private area. In addition, they told us how they ensured they tried to cover people as much as possible when providing personal care. However, some people told us that the way staff cared for them did not always support their dignity. One person living at the home told us that staff would wash them while they were sitting on the commode.

People were not always fully supported to be as independent as possible. One relative said in regard to her family member, "She wanted to get up and was made to go back to bed. She says they are not letting her walk here, she gets up and uses her frame and says they make her get into a wheelchair."

We also found that some of the environmental factors did not support people's independence. We found that in some bedrooms we ran the hot tap for a number of minutes and the water temperature never rose above tepid. This meant people were unable to wash in hot water in the privacy of their bedroom unless someone fetched them some. This decreased people's ability to maintain their independence.

The provider also made the effort to ensure people were happy and supported them to enjoy special occasions. One person living at the home was celebrating their 80th birthday on the day we visited. The dining room had been decorated and they had a celebratory tea planned. In addition, they supported people who wanted to bring their pet into the home with them.

The home had a warm, friendly atmosphere. One relative said, "It's very much like a home environment, it's very homely." Another relative told us, "It's lovely, the place feels like a home. Even the grand-children are happy to come and visit grandad here, it's like visiting him at home not in an institution."

People were able to spend private and quiet time with their relatives. Whilst most of the social activity appeared to take place in the main lounge there were two other small lounges where people could sit quietly or have private conversations with relatives. A relative confirmed this saying, "There's lots of quiet, private areas to sit and chat."

Mealtimes were a pleasant experience for people. People were offered a choice of where to sit and meals were served table by table so that no-one was sitting waiting whilst others at the same table were eating. Everyone enjoyed the meal and almost all finished their main course. We saw that staff asked people if they had finished before taking away plates. One person commented on the size of her pudding as it was too big. They were offered, and given, a smaller portion. People were offered a variety of drinks which included squash, wine, beer and shandy. Staff knew people's likes and dislikes and offered people appropriate choices. The cook went round and asked people if they were alright. We saw she moved one person closer to the table and ensured they were comfortable and that they encouraged another person to use their spoon rather than a knife.

There did not appear to be pressure on people to finish meals by a certain time. At 2 pm we saw there were two people still sitting in the dining room having their desert. Staff were still attentive and chatted to them as they went about tasks in the dining room and kitchen. People told us that they were offered choices about their lives. People told us they could get up and go to bed when they wanted. One person said, "You can get up and go to bed more or less when you want. I go late. Basically they'll ask you but you can say no I want to stay up."

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy living at the home and that the care provided met their needs. One person told us, "I've put on weight since I came here, I was poorly and depressed. I'm not depressed now in fact I really love it here." A relative said of the staff, "They are very friendly, always make you feel welcome. They seem genuinely interested in the residents' care." People told us that challenging behaviour by those people perhaps confused or distressed was handled well by staff. One relative said, "They just chat to them, calm them down."

People had been included in planning their care. Records showed that people or their family had signed the care plans to show they were happy with the plan. However, care plans were not person centred and did not accurately reflect people's needs or support staff to provide individualised care. For example, two of the care plans we looked at recorded that people should use and be strapped into a shower chair when bathing. Staff confirmed that both these people were independent in the shower and were able to stand in the shower. Furthermore, some care plans recorded that when people became distressed they may be confused and aggressive. There was no information in the care plan to advise staff how they could assist the person to be calm and settled.

Relatives also told us that people were not always supported to follow advice from the community nurses. One relative told us, "[Name] is diabetic. The nurse comes in quite regularly to dress her legs. She has to have them up and they weren't doing that. I think they have a reclining chair that supports her to have her legs up now". The community nurses also raised this delay in providing appropriate care as a concern. Staff confirmed and we saw that the person was now supported to have their feet raised.

People were assessed so that staff knew what activities they would enjoy and be able to engage with. An activity coordinator was in the home three days a week to support people to participate in group and individual activities and to access the community if desired. The activity coordinator told us that they also had systems in place so that other staff could encourage activities when they were not around. These included seated exercise to help maintain people's mobility, music quizzes, arts and crafts and visits to garden centres or walks around the village. The Activity Co-ordinator told us that the home had links with the local community engaging with the local churches and community groups.

People told us that they did enjoy the activities provided. One person told us, "We play games a lot, there's enough to do. When it's the activity coordinator's day off we'll have a film on, I enjoy that." A relative told us, "Every time we come the activity coordinator is playing games with them, ball games or dominoes, she does their nails".

We saw there was a notice telling people how to complain in the main entrance. People told us they were happy to raise complaints with the Provider or other staff. Relatives we spoke with said they knew who to go to if they had any worries or complaints. They felt the provider was often seen about the home and that they could go to them with any issues.

Requires Improvement

Is the service well-led?

Our findings

The registered provider had audits in place to monitor the quality of care that people received. Some of the audits had been completed effectively and they had identified areas for improvement. However, we saw that the improvements were not always consistently actioned. For example, consistent and sustained change had not been made to ensure that people had access to hand wash in their bedrooms and in communal bathrooms and toilets. Other audits had not identified the concerns we found at our inspection. For example, care plan audits had not identified that care plans did not contain enough person centred information to provide individualised care. Therefore the systems could not be relied upon to ensure that people were receiving the standards of care they should be able to expect.

The provider had taken action following our last report and had made changes to improve the safety of people living at the home, For example they had ensured that they had fitted restrictors to all the windows. However, their health and safety audits had not supported then to identify other areas of concern. An example of this was water that was scalding hot in some areas of the home and radiator covers which were not securely fixed to walls.

The provider had not fully understood the regulations in relation to the checks they needed to make when they employed staff. Therefore they had failed to complete the appropriate checks needed to ascertain if people were safe to work with people living at the home. This lack of understanding had increased people's risks of receiving inappropriate care or unsafe care.

This was a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

People living at the home, their relatives and visiting health care professionals had been asked for their views on the care they received. Record showed a quality survey had been completed in April 2017. Comments included that people were excellently cared for in all aspects of care. No-one we spoke to was aware of any resident's or relatives' meetings. However, because the home was small people were kept up to date with changes to the care and any concerns each time they visited the home. One relative told us, "The provider is lovely, I have no complaints and they tell me when anything happens or it they needs anything."

People told us that the staff supported each other. A relative told us, "They have a low staff turnover, a stable team. They work well together." A member of staff told us that the other staff had been very helpful during their induction and had been supportive when they had needed help and guidance

Staff told us that if they had any concerns they would raise them with the provider or senior members of staff and that they were confident there issues would be resolved. For example if a member of staff had done something incorrectly then the provider would address this. They told us they were able to talk to the provider in a confidential manner about any issues with staff, people living at the home and their lives outside work.

The provider had put systems in place which allowed staff time to talk to them about any concerns. In addition, regular meetings were scheduled to keep staff up to date on the changes in the home. A member of staff told us that she had six monthly supervisions with the manager and that team meetings were held every two months or sooner if there was a need. We saw the last meeting had been held in April 2017. We saw staff had discussed issues around medicines, the laundry and ensuring people's continent's issues were addressed.

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 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that systems to assess, monitor and improve the quality and safety of care, or systems to assess, monitor and mitigate risks to people were effective. Regulation 17(1)(2)(a)(b)

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 did not ensure recruitment processes ensured that the appropriate checks were carried out on people they employed. Regulation 19(3)(a)