Red Homes Healthcare Limited

Red Rose Care Community

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Red Rose Care Community is a care home that provides personal care for up to 65 people. The home is split into three areas, Serenity which support people with health and nursing needs, Memory which supports people who are living with dementia, and, Castle which support people who have needs associated with growing older. At the time of the inspection 31 people lived at the home. Due to concerns identified at our August 2018 inspection, we took action to restrict admissions to the home. This remained in place at the time of this inspection.

People's experience of using this service: People were placed at risk of harm as risks associated with their care and support were not always managed safely. Opportunities to learn from incidents had been missed which meant people may have been exposed to the risk of harm. Although people told us they felt safe, action had not always been taken to protect people from improper treatment and abuse. The home was clean and hygienic; however, infection control procedures were not followed by all staff. Overall there were enough staff and safe recruitment practices were followed.

Staff required more effective training and support to enable them to provide high quality care. Although people were supported to have maximum choice and control of their lives, staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Mealtimes were positive experiences; however, more work was needed to ensure risks were managed safely. People had access to a range of health care professionals. The home was adapted to meet people's needs.

People's right to privacy and to be treated with dignity were not always upheld. People told us staff were kind and caring. However, staff did not all read care plans which placed people at risk of inconsistent support. There was an inconsistent approach to involving people in decisions about their care and support. People were supported to be as independent as possible.

People did not always receive personalised care that met their needs. People were not consistently provided with opportunity for meaningful activity. People were supported to raise issues and concerns and there were systems in place to respond to complaints. People and their families were given an opportunity to discuss their wishes for the end of their lives and they were provided with compassionate care in their last days of life.

Systems to ensure the safety and quality of the service were not fully effective. This failure to identify and address issues had a negative impact on the quality of the service provided. The management team were responsive to feedback and took action to address issues identified. Feedback from people, families and staff was used to drive improvement. There was positive partnership working with health professionals.

The service met the characteristics of Requires Improvement in all areas. For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: Inadequate (report published on 8 January 2019). At the last inspection in August 2018, we asked the provider to take action to make improvements in relation to promoting dignity and respect, providing person centred care, risk management, staffing and governance and leadership. At this inspection, enough improvement had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since our inspection in August 2018. During this inspection the provider demonstrated that some improvements had been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: We have identified breaches in relation to person centred care, safeguarding, safe care and treatment, staffing and leadership 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.

After our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report . In response, the provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk.

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

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not consistently effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not consistently caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

Details are in our Well-Led findings below.

Red Rose Care Community

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: This inspection was carried out by two inspectors, a specialist nursing advisor and an Expert by Experience who had personal experience of caring for someone who uses services that support older people.

Service and service type: Red Rose Care Community is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who had applied to register registered with the Care Quality Commission. This was in progress at the time of our inspection. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did before the inspection: Before the inspection we reviewed any notifications we had received from the service and information from external agencies such as the local authority. We did not ask the provider to complete a Provider Information Return (PIR). This is information we require providers to send us to give key information about the service. We gave the provider and registered manager the opportunity to share this information during the inspection.

During the inspection: We spoke with five people who lived at the home and the relatives of seven people. We also spoke with four staff, a member of the catering team, two nurses, the manager and the chief operating officer. We reviewed records related to the care of eight people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, three staff files and the staff duty rota. We looked at documentation related to the safety and suitability of the service and spent time observing

interactions between staff and people within the communal areas of the home.

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was a risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
• People were subject to unnecessary control and restraint. Records for one person documented that staff used 'physical force' to manage their behaviour, this approach was not specified in their care plan and staff did not have training in this area. Staff had documented that they were concerned about causing injury to the person.
• In addition, staff disclosed that they had observed other staff using physical intervention on people. The use of unnecessary control and restraint could have had a negative impact upon people's physical and emotional wellbeing and may have led to injury.

The failure to protect people from improper treatment and abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• After our inspection we wrote to the provider and asked them to take urgent action to ensure people were not subject to physical restraint. The provider told us they had taken action to ensure restraint was no longer used.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess and manage risks relating to the health, safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found ongoing concerns.

• People were not always protected from risks associated with their care and support. There was an inconsistent approach to risk management. For example, staff did not follow professional advice to reduce the risk of choking. A specialist diet had been advised for one person; however, we saw this was not followed. This placed the person at risk of choking.
• Risks arising from people's behaviours were not managed safely. Care plans did not contain enough detail of how to safely support people whose behaviour could pose a risk to others. One person frequently became distressed resulting in them attempting to hurt others. Although their care plan gave guidance for staff, records did not evidence that staff followed this guidance. This meant the person remained distressed which placed them, and staff, at risk of harm.

Learning lessons when things go wrong
• Lessons were not always learned when things went wrong. There had been a failure to learn from

behavioural incidents. Records for one person showed that strategies to help manage their behaviour frequently had 'no effect', with evidence of continuing verbal and physical aggression. No action had been taken to review and learn from the behaviour charts to try out different strategies. This failure to review and learn from behaviour placed people at risk of unsafe support.

This was an ongoing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• After our inspection we wrote to the provider and asked them to take urgent action to ensure risks associated with choking and behaviour were managed safely. The provider told us they had taken action to address this.
• Risks associated with the environment were managed safely. For example, plans were in place to ensure people could be safely evacuated from their room in the event of an emergency.

Staffing and recruitment

At our last inspection the registered provider had failed to make sure there were enough staff to meet people's needs and keep them safe. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 18(1).

• Overall, there were enough staff available to meet people's needs and ensure their safety. Most people and their relatives felt there were enough staff. One person told us, "I think there are plenty of staff and they are very quick to come if I need them." However, there were conflicting views from some relatives of people on Memory, who said their family members had to wait for support when staff were busy.
• Staffing levels were calculated based upon individual need. The manager told us they normally staffed above this level. Short notice absences were covered, and agency staff were occasionally used. Records show enough staff were deployed.
• Safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

Preventing and controlling infection
• The service was clean and generally well maintained, however there were some inconsistencies regarding infection control measures. Since the last inspection a nurse had been appointed as infection control lead, however we found further improvements were required to ensure staff followed safe infection control practices.
• During the inspection we saw examples of staff not wearing appropriate protective clothing while providing care. We also observed a member of staff putting food down on a recently used pressure cushion. This increased the risk of infection spreading.

Using medicines safely
• People received their medicines as prescribed. Medicines were managed safely, and people told us they got their medicines when they needed them.
• Detailed information was available for staff about how each person preferred to take their medicines and any allergies they had. Staff received regular training in medicines administration.

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our August 2018 inspection we found staff did not have enough training and competency. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found further improvements were required.

• Staff did not have training in key areas, such as dementia awareness and safely supporting people whose behaviour could pose a risk to others. We observed this had a negative impact on the quality of service provided in some areas of the home. This was also reflected in feedback from some people's relatives who told us they felt some staff lacked skill in supporting people living with dementia.
• Staff had training in other areas, however, further work was needed to embed learning. For example, although staff had training in infection control, staff did not always follow good infection control practices.

The provider's failure to ensure staff had the skills and knowledge to support people safely and effectively was an ongoing breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The manager had identified the above gaps and had booked additional staff training about supporting people who are living with dementia and how to safely manage people's behaviours.
• Staff had regular supervision and support to manage performance and support staff development.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People told us they were supported with their health needs and most people's relatives said they were kept informed about any changes to people's needs.
• Care plans contained clear, personalised information about people's health conditions. However, some staff were not reading care plans so this posed a risk of people receiving inconsistent support.
• Records showed staff sought advice from external professionals when people's health needs changed. There was evidence that advice had been sought from external health professionals, such as speech and language therapy. However, we observed staff did not always follow this.
• Systems were in place to ensure information was shared across services when people moved between them. This helped ensure people received person centred support.

Ensuring consent to care and treatment in line with law and guidance

At our August 2018 inspection we found the provider had failed to provide care in line with the principles of the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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. We checked whether the service was working within the principles of the MCA.

• People's rights under the MCA were respected. When people's ability to consent was in doubt assessments had been conducted and decisions had been made in their best interests. Overall, consideration had been given to less restrictive options to ensure people's rights were respected.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• DoLS had been applied for as required. Where conditions were in place the home was working towards complying with them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to them moving into Red Rose. This was used to develop care plans for each person.
• Nationally recognised tools were used to assess risk and manage care. For example, a nationally recognised tool was used to assess the risk of malnutrition. The nursing team frequently checked national good practice guidance to ensure they were up to date with the latest developments.

Supporting people to eat and drink enough to maintain a balanced diet
• People had enough to eat and drink. People told us they liked the food. One person said, "The food is very nice."
• Overall, mealtimes were positive occasions. Staff provided timely assistance to people when needed. People were offered choices and dietary preferences were catered for. Changes to the menu and timing of meals were planned and people were positive about this.
• Further work was needed to ensure risks associated with eating and drinking were managed safely. We have reported on this further in the 'Is this service safe' section of the report.
• When people were at risk of losing weight, staff monitored their weight regularly and made referrals to specialist health professionals as needed.

Adapting service design and decoration to meet people's needs
• The home was adapted to meet people's needs. Improvements had been made to the environment since our last inspection. Serenity had been thoughtfully renovated and included large rooms for people who required medical equipment, rooms for relatives so they could stay with family members who were in their last days of life and a multi faith room.
• The needs of people living with dementia and memory loss had been considered. There was dementia friendly signage throughout the home to help people find their way around and murals and other items of

interest, such as sensory objects.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant people were not always treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At our August 2018 inspection we found people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008. At this inspection we found some improvements had been made and there was no longer a breach of the legal regulation, but further work was needed to ensure high quality care.

• Overall, staff respected people's right to privacy. However, during our inspection we heard staff discussing a person's continence needs in a communal area. This was not dignified and did not respect the person's privacy.
• Some practices within the home did not promote people's dignity. Due to a lack of storage space, continence items were stored in people's bedrooms. This meant these were visible to visitors and family members. This was not dignified.
• People's sensitive personal information was not always stored securely. Although care records were stored in locked offices, the keys were easily accessible which meant there was a risk unauthorised people could gain access to confidential information. The manager told us they would take immediate action to address this.
• People were supported to be as independent as possible. Care plans contained information about how to promote each person's independence and we saw staff encouraging people's independence throughout our visit.

Ensuring people are well treated and supported; equality and diversity
• People told us most staff knew them well, although some commented this varied between staff. Care plans contained information about what was important to people such as their likes, dislikes and background, However, some staff had not read care plans, which placed people at risk of inconsistent support.
• Overall, people were positive about the atmosphere of the home and the caring attitude of the staff. One person told us, "All the staff are very nice and will sit and chat to you." A relative said, "The staff are really lovely and make me feel very welcome. They all have smiley faces."
• People told us they were treated fairly and were free from discrimination.

Supporting people to express their views and be involved in making decisions about their care
• There were some occasions when people's choices were not respected. Some people had to share equipment, such as specialised chairs. This meant people's choices about where they spent their time could not always be respected.

• People told us staff consulted with them about their day to day care and said they felt listened to. Overall, we saw that staff offered people choices and respected their decisions. We observed several occasions where staff did not offer choices of drink or snack, this appeared to be a habit. The manager told us they would take action to address this.
• Most people's relatives felt involved in the care of their family members. A relative told us, staff always called them to let them know about changes in their relations care.
• People and their families told us they had been involved in developing their care plans. A relative said, "I am very involved with [relation's] care plan." People's had shared information about their life history, families and likes and dislikes. Care plans also included clear information about people's communication needs. Despite this, staff failure to read care plans placed people at risk of inconsistent support.
• People had access to an advocate if they required one to help them express their views and there was information about advocacy displayed in the service. No one was using an advocate at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

At our last inspection in August 2018, we found the provider had failed to ensure that people received a service that met their needs, preferences and provided social stimulation. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008. At this inspection we found continued concerns in this area.

• People's needs were not always met. Care records showed several people had not had their teeth brushed for a period of 12 days. There were no oral health care plans in place and staff had not taken any action to ensure better oral care. Records also showed several people had not been offered a bath or shower in the 12 days leading up to our inspection. This did not meet people's needs and issues such as poor oral care could have had a negative impact upon people's wellbeing.
• People were at risk of receiving inconsistent, support that did not meet their needs. While care plans were, overall, clear and detailed, several staff told us they did not read care plans but instead learnt about people's needs from other staff. One member of staff told us, they "would not know where to start" in finding information in a care plan. This placed people at risk of receiving unsafe support that did not meet their needs.
• People were not consistently provided with opportunities for appropriate activity and occupation. A relative told us, "I think there could be more in the way of stimulation for the residents." The provider employed external entertainers to provide activities at the home. We saw that people enjoyed this very much and feedback was positive. However, at times when there were no external entertainers there was a lack of structure and stimulation for some people. A relative told us, "[Person's name] tends to be left in their room. There are not enough staff for them to do things like (read a book to them)."
• Staff did not always take natural opportunities to engage with people. We observed staff were present in communal areas, primarily in a supervisory capacity. Although staff were friendly in their approach, they did not take opportunities to meaningfully engage with people. This did not meet people's needs.

The provider's failure to support people in a consistently person-centred way and to meet their needs was an ongoing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

• The registered manager told us people's diverse needs were identified before they moved in to the home and care plans contained details of any support people required to ensure their needs were met. People's religious and cultural needs were accommodated. Local religious groups visited the home regularly. The manager shared an example of where they had supported people to express their needs related to their

sexuality.
• The manager was working towards meeting people's rights under the Accessible Information Standard. This is a set of standards to ensure people have equal access to information regardless of disability or impairment. They told us information could be made available in different formats and added they were developing pictorial resources to make information more accessible to people. □

End of life care and support
• People were provided with caring and compassionate support at the end of their lives. The home had been adapted to ensure people had space and privacy in their final days of life and the needs of people's families had also been considered.
• A funeral director had spent time with the staff team talking about their role to try and help staff become more familiar and comfortable in talking about end of life care.
• The staff team held a celebration of people's lives at the home when people passed away.

Improving care quality in response to complaints or concerns
• People felt comfortable raising any complaints or concerns. Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns.
• There was a complaints procedure on display informing people how they could make a complaint. Complaints had been investigated and responded to in an appropriate and timely manner.
• There were several family members who were not happy with the response to complaints. This was being dealt with by the provider at the time of our inspection.

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 inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our August 2018 inspection we found concerns about leadership and governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008. At this inspection we found continued issues in this area.

• Systems to ensure the safety and quality of the service were not effective. Concerns had not been identified in some areas due to a lack of governance and audit systems. For example, failure to provide adequate oral care or offer people regular baths and showers had not been identified as the care records were not checked regularly. This lack of oversight had resulted in people receiving care that did not meet their needs.
• Systems to review and learn from incidents were not comprehensive so had not identified issues. Although falls were regularly audited by the manager there was no system in place to analyse behavioural incidents. This lack of systems had resulted in a failure to identify unsafe and ineffective care practices.

The failure to ensure effective governance was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our August 2018 inspection we found, the provider had failed to notify CQC of some events within the service, which they are required to by law. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations. At this inspection we found improvements had been made in this area.

• The provider had notified us of events as legally required.
• It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. The provider had displayed their most recent rating in the home.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility;
• The provider and manager had a shared vision for the home. They aimed to provide a person-centred service and were aiming to provide outstanding care to people. They understood lots of work was needed to achieve this goal and were committed to making it work. The manager was aware that further work was

needed to ensure all staff committed to achieving the vision and told us they regularly discussed their vision in regular staff meetings.
• Overall, people and their families were very positive about the home, staff and management team. A relative told us, "Overall, I am happy. I think standards have been raised over the last six months. There are regular faces and more continuity of care. [Manager] is very approachable," another relative told us, "I feel there is more trust now."
• However, this was not a view shared by everyone, several family members told us they lacked confidence in the management team and felt the home did not provide the level of quality they expected. We discussed this with the provider and local authority who told us they would work with the home and relatives to try to resolve some of the issues.
• The manager of Red Rose Care Community had applied to register with the CQC. They had started in post in Autumn 2018 and most people who used the service, relatives and staff were positive about the impact they had. Staff told us the manager was approachable and a good leader. A member of staff said, "I feel very supported by [the manager], can ask them anything."

Working in partnership with others
• The team at Red Rose worked in partnership with other professionals. For example, specialist health professionals had delivered training at the home on hydration and nutrition to try to improve the care and support provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and their families were involved in decisions about the home. One person told us, "Sometimes the staff will ask for any suggestions when we are all together. I feel I could put forward an idea at any time and if they can't do it, they will tell us why." Regular meetings were held where people were consulted about activities, food and the decoration of some areas. There were also regular relatives' meetings which were led by family members. People's families had a strong voice in the running of the home.
• People's families were kept up to date about the care of their relatives. The manager wrote to relatives each month advising them of any incidents and inviting them to discuss this further.
• There were regular staff meetings, these were used to share news and information with staff and to discuss areas of concern and improvements needed.
• The manager had considered the diverse needs of the staff team and had organised a basic English and maths course for staff who had English as a second language.

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 People were not always provided with person centred care that met their needs. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not consistently provided with safe care and treatment. Risks such as choking were not managed safely and there had been a failure to learn from some incidents. Regulation 12(1)

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 had failed to protect people from improper treatment as people were subject to unnecessary restrictive practices. Regulation 13(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the safety and quality of the

	home were not fully effective. Regulation 17(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff had the skills and knowledge to support people safely. Regulation 18(2)