Ashberry Healthcare Limited

# Broomy Hill Nursing Home

## Inspection report

43 Breinton Road
Hereford
Herefordshire
HR4 0JY

Tel: 01432274474
Website: www.ashberry.net

Date of inspection visit:
16 January 2017
18 January 2017

Date of publication:
28 February 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 16 and 18 January 2017 and was unannounced.

Broomy Hill Nursing Home provides accommodation with nursing and personal care to a maximum of 40 people with dementia-related illness and mental health needs. There were 35 people living at the home when we visited.

A registered manager was in post and present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection on 10 and 12 August 2016, we found breaches of Regulations of the Health and Social Care 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulation 2009. We gave the service an overall rating of requires improvement. These breaches related to the provider's failure to always treat people with dignity and respect, manage people's medicines safely and notify us of an allegation of abuse involving a person who lived at the home. The provider sent us an action plan setting out the improvements they intended to make.

At this inspection, we found the provider had made some improvements to the service. However, people were still not always treated with dignity and respect. In addition, staff had not received appropriate training, supervision and appraisal. Some staff also still lacked confidence in the registered manager's ability to act on things brought to their attention. The provider's quality assurance systems had still not enabled them to address significant shortfalls in the quality of the service.

Staff understood how to recognise and report abuse. The risks associated with people's care and support needs had been assessed, recorded and plans implemented to manage these. There were sufficient numbers of staff to safely meet people's needs, although staff deployment could be improved. People's medicines were managed and administered in a safe manner.

Staff sought people's consent to care and protected their rights under the Mental Capacity Act 2005 (MCA). Staff supported people to have enough to eat and drink, and to have a balanced diet. People's day-to-day health needs were met, and staff supported them to access healthcare services.

Staff took a patient, caring and compassionate approach to their work with people. They encouraged people to express their views and be involved in decisions, where possible. People's care and support was shaped around their individual needs. Staff supported people to spend time doing things they enjoyed and found interesting. People's relatives knew how to complain about the service, and felt confident their concerns would be appropriately handled. The provider encouraged a positive and open dialogue with people's relatives. Staff found the management team approachable.

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

We always ask the following five questions of services.

### Is the service safe?

**Good**

The service was safe.

The provider had taken steps to protect people from harm and abuse. Staff understood how to recognise and report abuse. The risks connected with people's care and support needs had been assessed and managed. People received their medicines safely from trained staff.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff training, supervision and appraisal had not been kept up to date. Staff sought people's consent to care. People had the individualised support they needed to eat and drink. Staff supported people to access healthcare services.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People's privacy and dignity was not always protected and promoted by staff. Staff adopted a caring and compassionate approach to their work with people. People were supported to express their views about day-to-day matters that affected them.

### Is the service responsive?

**Good**

The service was responsive.

People received personalised care and support. Staff supported people to spend time doing things they enjoyed and found interesting. People's relatives knew how to complain to the provider, and felt confident about doing so.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

The provider encouraged a positive and open dialogue with people's relatives. Some staff lacked confidence in the registered manager's ability to act on things. The provider's quality

assurance systems had not enabled them to address shortfalls in the quality of the service people received.

# Broomy Hill Nursing Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 18 January 2017 and was unannounced. The inspection team consisted of two inspectors 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 service.

As part of our inspection, we looked at the information we held about the service, including the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority and Healthwatch for their views about the service.

During our inspection, we spoke with two people who used the service and 11 relatives and a visiting aromatherapist. We also talked to 14 members of staff, including the registered manager, the provider's external quality consultant, the clinical lead, nurses, activities staff, maintenance staff, kitchen staff, senior carers and carers. We looked at two people's care records, medicine records, MCA and DoLS-related records, staff supervision and training records, records of complaints, menus and records associated with the provider's quality assurance systems

We also 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.

Good

# Is the service safe?

## Our findings

At our last inspection, we found the provider did not always manage people's medicines safely. Nurses had asked some staff to give people their medicines without training or supervision. In addition, the refrigerator that held medicines requiring cold storage was not operating within the recommended temperature range, and the manager had taken no action to put this right. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider was meeting the requirements of Regulation 12. All of the staff we spoke with told us that, since our last inspection, only the nurses handled and administered people's medicines. Our observations during this inspection confirmed this was the case. We checked the refrigerator used for storing medicines that required cold storage and found this was now operating within the recommended temperature range. During our inspection, we looked at other aspects of how the provider managed people's medicines, including the storage arrangements for other medicines and the medicines records staff kept. We found the provider had put systems and procedures in place to ensure people received their medicines safely and as prescribed. For example, the management team had produced written guidance on the use of "as needed" medicines, to ensure the nurses understood the circumstances in which these were to be offered to people. People's relatives confirmed their family members received the right support with their medicines. On this subject, one relative told us, "[Person's name] gets what they need, when they need it."

People's relatives felt the home offered a safe environment for their family members, and that staff adopted safe work practices. One relative told us, "They (staff) are very careful with moving people around; they support and watch them the whole time." Another relative described the steps staff took to ensure their family member did not develop pressure sores whilst being cared for in bed. The management team carried out an assessment of the risks associated with people's individual care and support needs. This assessment took into account important aspects of people's safety, including any risk of falls, malnutrition or pressure sores. They implemented plans to manage any significant risks and protect people from avoidable harm. The staff we spoke with demonstrated good insight into people's current risk assessments.

People's relatives were satisfied with the measures taken by the provider to keep their family members safe. One relative praised the manner in staff had reviewed and adapted their family member's care and support to protect them from the risk of injury due to falls. This person explained, "They (management) keep reviewing what's best for [person's name]." People's relatives felt the manager and staff team involved them in decisions about how to keep their family members safe at the home. One relative also commented on the balanced approach the provider took to protecting people from harm, which respected people's right to independence. Although they had no such concerns at present, people's relatives knew how to raise any concerns about their family members' safety and wellbeing with the provider, if they needed to.

The staff we spoke with knew how to recognise abuse, and understood the need to report any such concerns to a senior or the manager immediately. The provider had developed formal procedures to ensure that any abuse concerns were reported to the appropriate external authorities, recorded and investigated.

Our records showed that they had previously made external notifications in line with these procedures. In the event that people were involved in an accident or incident, staff understood the provider's procedures for recording and reporting these events. We saw the management team used these reports to identify causes and trends, and take action to reduce the risk of reoccurrence.

The provider had developed procedures to ensure staff had up-to-date information on the current risks to people, themselves and others. These included daily handovers between staff, and meetings each morning for the heads of departments. Handover is a face-to-face meeting in which staff leaving duty pass on important information about people's health and wellbeing to those arriving on shift. Staff told us communication within the home was generally good, and that they had the information they needed to keep people safe.

We looked at whether there were sufficient numbers of staff to safely meet people's needs. At our last inspection, we found staff were under significant pressure to address people's competing care needs. People's relatives also expressed mixed views about the adequacy of the staffing arrangements at the home. During this inspection, people's relatives spoke more positively about the level of staff support available to their family members. One relative told us, "I go to the home at various times of the day, and there always seems to be enough staff on duty." Another relative said, "With a quick shout or snap of the fingers, a couple of extra staff come running if one of them (staff) wants help."

The registered manager told us they continued to monitor and assess staffing requirements based upon people's individual care and support needs. Since our last inspection, the provider had reviewed and increased staffing levels on this basis. There was some acknowledgement amongst staff that the staffing situation had improved, and that staff sickness levels had reduced. Our observations of the care provided during our inspection indicated that there were enough staff on duty to meet people's needs safely, but that the day-to-day deployment of staff could be improved. For example, during the afternoon, we saw a single staff member struggling to meet people's competing requests for assistance in the home's main lounge. We discussed our observations with the registered manager who assured us they would look into this. The provider did not make use of agency staffing, to ensure greater consistency in the care and support provided. All potential employees underwent checks, before starting work at the home, to ensure they were suitable to work with people. These consisted of an enhanced Disclosure and Barring Service (DBS) check and the provision of employment references. The DBS carries out criminal records checks to help employers make safer recruitment decisions.

Requires Improvement

# Is the service effective?

## Our findings

During our inspection, we looked at how the provider ensured staff had the support, training, supervision and appraisal required to carry out their duties effectively and meet people's needs. As part of this, we reviewed the provider's training records. We found that a significant number of staff had yet to complete the provider's mandatory training. This included training in safeguarding adults, health and safety, food hygiene training, first aid and infection control. In addition, where staff had participated in training, appropriate refresher training had not been consistently organised at the provider's stated intervals.

We discussed our concerns in relation to staff training with the registered manager. They acknowledged that training and refresher training for a number of staff was out of date. They told us this lack of training activity, particularly over the course of 2016, was due to an oversight on their part. At the time of our inspection, the provider did not have a comprehensive plan in place to address these training requirements. The responses provided by the registered manager did not assure us that they understood the importance of staff training.

Staff expressed mixed views about the regularity of their supervision meetings with the manager or another senior member of staff. One staff member described staff supervision meetings as being "hit and miss". Another staff member said, "I can't remember the last time I had a supervision." The registered manager confirmed that staff supervision meetings and appraisals had not taken place on a consistent basis for some time. They indicated that these meetings had lapsed significantly over the entire course of 2016, as their focus had been on other matters. They told us supervision meetings would take place on a quarterly basis moving forward. Again, the responses provided by the registered manager did not assure us that they fully understood the role and importance of staff supervision and appraisals. Regular supervisions and appraisals give staff valuable opportunities to receive feedback on their work, reflect on their practice and how this might be improved, and discuss the additional training and development required to support these improvements. Our observations of people's care and support indicated that working practice needed to be improved in relation to the promotion of people's privacy and dignity.

We were not assured that staff had received the consistent training, supervision or appraisals needed to support them in carrying out their duties. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives felt staff had the necessary skills, knowledge and experience to meet their family members' care and support needs. One relative told us, "They (staff) seem to know exactly what they are doing." Another relative said, "They (staff) do what you would expect; they do what is necessary when it's necessary."

We looked at how the provider protected people's rights under the Mental Capacity Act 2005. The Mental Capacity Act (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.

At our last inspection, we found the provider was not always working in accordance with the requirements of the MCA. Best interests meetings had not been held in relation to the decisions taken to covertly administer some people's medicines. Where other decisions had been made in people's best interests, these had not been clearly or appropriately recorded. At this inspection, we found evidence of a more robust best-interests process around the use of covert medicines. The registered manager confirmed that they had agreed any use of covert medicines with people's GPs and, whenever possible, their relatives. We saw the standard of record keeping in relation to other best-interests decisions made on people's behalf had also been improved.

The staff we spoke with had an understanding of the implications of the MCA for their day-to-day work with people and the need to seek people's consent to care. People's relatives confirmed that staff demonstrated respect for their family members' ability to make decisions. One relative told us, "They (staff) always ask whether it's alright before they do things; they always try to get people's cooperation." Another relative said, "They (staff) will explain and tell [person's name] what they're going to do."

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). The registered manager had carried out an assessment of each person's capacity and their individual care and support arrangements, and had made DoLS applications on this basis. Where people had been granted a DoLS authorisation, the registered manager and clinical lead demonstrated an awareness of any conditions placed upon these. During our inspection, we saw evidence that these conditions were being complied with.

We looked at how the provider supported people to have enough to eat and drink, and to have a balanced diet. At our last inspection, we found the provider was not adequately involving people in decisions about what they ate. At this inspection, we found the management team had introduced greater choice in what people had for each of their main meals and was better supporting people to make choices in this area. People could choose from a variety of hot and cold options at breakfast, and were supported to choose between two options for both lunch and their evening meals. The registered manager explained that they in the process of introducing additional food picture cards to help people make their mealtime choices.

People's relatives were satisfied with the quality and quantity of food and drink on offer at the home, and the support their family members received with eating and drinking. One relative told us, "They (people) have a very good diet. [Person's name] enjoys all their food and never leaves any of it. They (staff) are very patient in feeding them." During our inspection, we saw people were offered plenty of drinks and snacks throughout the day, and that they received patient, individualised support and encouragement to eat and drink at mealtimes.

The provider had put systems and procedures in place designed to ensure that any risks around people's eating and drinking were assessed, recorded and plans implemented to manage these. We saw evidence of the involvement of the local speech and language therapy team in relation to the support people needed with eating and drinking. During our inspection, a relative made us aware that their family member had a painful medical condition triggered by a particular food. Although the majority of the staff we spoke with were aware that this food was to be avoided for this person, the cook indicated that they had not been given this information. We also found the information recorded in relation to this food interaction in the person's care file was unclear. We discussed this issue with the registered manager and clinical lead who told us they would address this issue.

People's relatives told us staff played a positive role in ensuring their family members' day-to-day health

needs were met, and helping them to access healthcare services. They felt staff responded promptly to any changes or deterioration in their family members' health, seeking professional medical advice and treatment if needed. On this subject, a relative told us, "They (staff) are on the ball." Another relative described how the management team had helped them to arrange a beneficial meeting with their family member's GP to discuss recent changes in their health and mobility. Staff confirmed that they supported people to attend medical appointments and routine health monitoring as needed. We saw evidence in people's care files of the range of healthcare professionals involved in their care and the healthcare reviews that had been completed.

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection, we found staff did not always treat people with dignity and respect. We saw staff openly discussed people's personal care in front of others, and did not always meet people's personal care needs in a discreet and sensitive manner. Staff raised concerns about the way people were sometimes spoken to and treated by their colleagues. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In their action plan, the provider told us they intended to give staff additional training on dignity and respect and carry out additional observations of staff working practice in the home.

At this inspection, we saw evidence that people were being treated with greater dignity and respect, and that the provider was now meeting the requirements of Regulation 10. People's personal care needs were being handled in a more discreet manner, and not openly discussed in the presence of others. The provider had organised a dignity workshop for 13 staff since our last inspection. The clinical lead told us that they and the registered manager had also monitored staff working practice more closely, promptly challenging any issues related to the promotion of people's dignity.

However, we found the provider was still not doing enough to protect and promote people's privacy and dignity. We saw three people were left wearing soiled bibs for a significant period after their breakfast had finished. One of these people was wearing a shirt with missing buttons that exposed their stomach. When we raised this issue with a member of staff, we were told that all of this person's shirts were in a similar condition, and that their buttons were never sewn back on. After being provided with a jumper to put on over their shirt, this person said, "That's better." We also observed a member of staff eating their own sandwich whilst they supported a person to eat their breakfast. Staff told us that, although there was an increased awareness of people's rights to privacy and dignity amongst the staff team, there were continuing problems in this area. They explained that, due to a lack of alternative storage, hoists and wheelchairs were still stored in the bathrooms. Some of their colleagues persisted in allowing staff to enter bathrooms which were already in use by people to take the equipment they needed. One staff member explained, "People (staff) do knock now, but they are still welcomed in (by other staff)." Staff told us they had asked for engaged signs to be fitted on the bathroom and shower-room doors to discourage this practice, but that this had not yet been arranged by the management team.

We discussed these issues with the registered manager. They felt the recent staff training on dignity in care had significantly raised staff awareness in this area. However, they acknowledged that there was a need for further improvement in this area, and assured us they would look into these issues.

People's relatives felt staff adopted a caring approach towards their work, and took the time to get to know their family members well. One relative told us, "Ninety nine per cent of staff are fantastic in the way they treat residents. They take the time to put their arms around them and to have a chat. It makes the world of difference to people." Another relative said, "They (staff) have gotten to know [person's name], and they enjoy them." This person went on to say about staff, "You get that feeling that somebody really gets who your relative was and is." During our inspection, we saw a number of positive, caring interactions between

staff and the people who lived at the home. Staff demonstrated a patient and compassionate approach towards their work. For example, at one point a person became distressed regarding the whereabouts of their family. We saw a staff member took the time to locate pictures of the family members in question from this person's bedroom. They then showed and talk about these to the person, which clearly had a reassuring effect upon them.

The majority of the people living at the home were unable to give the provider their views about the care and support they received, or to be actively involved in the planning of their care, due to their dementia. However, staff demonstrated an understanding of how to encourage and support people to make or be involved in day-to-day decisions that affected them. This included supporting people to make choices in what they wore, ate or how they spent their time. The registered manager told us they encouraged people's relatives involvement in decision making and care planning, in order to benefit from their insights into their family members' wishes, needs and preferences. People's relatives confirmed their views were requested and listened to. The registered manager informed us that people would be supported to access independent advocacy services, as needed, to ensure their voice was heard in any important decisions to be made.

Good

# Is the service responsive?

## Our findings

At our last inspection, staff told us that time pressure due to a lack of staffing was having a negative impact upon their ability to provide consistent personalised care. At this inspection, some of the staff we spoke with acknowledged that the increase in staffing levels and reduced staff sickness had alleviated the pressure on them and allowed them to work in a more person-centred way. Our observations of how people were cared for in the home's communal areas indicated that staff now had more time to spend with people, although the deployment of staff could be improved.

People's relatives felt the care and support staff provided were shaped around their family members' individual needs. They were satisfied with the level of involvement they, as relatives, had in the assessment and planning of their family members' care needs. On this subject, one relative told us, "They (staff) involve me the whole time and they always take what I say seriously." Another relative said, "We've had a couple of meeting with them (management) about [person's name] and speak to [registered manager] on a fairly regular basis." People's relatives felt the provider valued their opinions about their family members' care and took these into account.

People's care files reflected an individualised approach to care planning, and included information about their life histories and preferences. Activities staff had also produced colourful small posters on each person's background, preferences and needs and displayed these outside their respective bedrooms. We found people's care plans often contained limited guidance for staff on how to meet their specific care needs. However, the staff we spoke demonstrated good insight into people's individual care and support needs. People's care plans were reviewed by the nurses on a regular basis, to ensure these remained effective and up to date.

Designated activities staff took the lead in supporting people to pursue their interests and join in with activities they enjoyed. People's relatives were pleased with the range and amount of activities on offer. One relative told us, "There seems to be quite a bit going on." Another relative said, "They (staff) are very good; they cater for what people can do. [Person's name] loves music and goes to a twice weekly music session." The activities coordinator explained that they focused primarily on one-to-one activities with people, but also ran group activities, had entertainers come into the home and organised regular trips out in the minibus. During our time at the home, we saw people involved in activities including flower arranging, aromatherapy, cards games and reading.

We looked at how the provider handled concerns and complaints from people, their relatives and others. People's relatives were clear about how to make a complaint to the provider, and felt confident their concerns would be dealt with appropriately. On this subject, one relative told us, "I would raise it with the nurse in charge and, if it hadn't been addressed, I would go to the manager." We saw the provider had developed a formal procedure to ensure all complaints were recorded, investigated and responded to appropriately. We reviewed the last complaint received regarding the service. We saw this had been subject to an investigation, following which a written response had been sent to the complainant. People's relatives felt the management team welcomed any other general feedback they had to offer about their family

members' care and support.

Requires Improvement

# Is the service well-led?

## Our findings

We looked at how the provider monitored and assessed the quality of the care and support people received. At our last inspection, we found the provider's quality assurance systems had not enabled them to identify and address the concerns we identified during our time at the home. At this inspection, we saw the clinical lead, registered manager and provider's senior management team carried out audits and checks designed to measure and improve the quality of the service. These included medication audits, care plan audits, catering audits, falls and complaints analysis and the senior management team's quarterly quality audits. The registered manager described how these quality assurance systems had led to some improvements in the service. These included changes in mealtime arrangements to better reflect people's eating preferences and more consistent record-keeping around the administration of people's medicines. The registered manager confirmed they received the necessary support and resources from the provider to achieve improvements in the service.

However, we were still not assured that the provider's quality assurance was as effective as it needed to be. Again, it had not enabled the provider to highlight and address, in a timely manner, the significant shortfalls in quality we identified during our inspection. These included the long-term lapse in staff supervision, appraisal and training, and the continuing need for improvement in the promotion of people's privacy and dignity.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, staff lacked confidence in the registered manager's ability to act on concerns brought to their attention by staff. At this inspection, some staff described an increased willingness on the part of the registered manager to deal with things. However, other staff still lacked faith in the registered manager's ability to act, or felt a continuing lack of clear leadership and direction. One staff member told us, "I have more confidence in the registered manager, but not completely." Another staff member said, "I wish they (registered manager) could be sterner, but they don't like confrontation." A further member of staff pointed towards the registered manager's failure to act on concerns they had raised about the attitude and conduct of a colleague, adding, "They need to be a manager, not our friend." All of the staff we spoke with felt the registered manager was approachable. One staff member told us, "[Registered manager] has a lot of good qualities. They are very keen to individualise the care and quite approachable. They have a heart for the residents." We discussed the issues raised by staff with the registered manager. They told us they took staff concerns seriously, and had addressed issues raised with them by staff.

People's relatives felt they had an open and honest dialogue with the management team. They had confidence in the management team's ability to keep them up to date about anything significant that involved or affected their family members. One relative told us, "They (management) are very good at keeping in contact with us about things. I've got a very good relationship with [clinical lead] and [registered manager]." People's relatives felt the provider would deal with any issues or concerns they raised regarding the service in a fair and open manner. They knew and spoke positively about the registered manager, who

they described as both "caring" and "approachable". One relative described the support, encouragement and confidence the registered manager had given them to go on holiday abroad, in the knowledge their family member would be well cared for at the home.

At our last inspection, we became aware that the provider had failed to tell us about an allegation of abuse involving a person living at the home. The registered manager was aware of the requirement to submit notifications of this nature, but had failed to do so by an oversight. Statutory notifications ensure that the Care Quality Commission (CQC) is aware of important events involving the people who use services and play a key role in our ongoing monitoring of services. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Since our last inspection, the provider had submitted statutory notifications to us in line with requirements of their registration. As a result, they were now meeting the requirements of Regulation 18.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's quality assurance systems and processes had not enabled them to identify and address significant shortfalls in the quality of the service. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not received the necessary training, supervision and appraisal to fulfil their duties. |