Yarrow Housing Limited

Angela House

Inspection report

41 Weltje Road
Hammersmith
London
W6 9LS

Tel: 02087418733
Website: www.yarrowhousing.org.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We conducted a comprehensive inspection of this service on 30 January, 6 February and 16 March 2017. A breach of legal requirement was found in relation to staffing levels. Following the inspection the provider wrote to us to state what action they would take to meet the legal requirement in regards to the breach. This unannounced focussed inspection commenced on 13 October 2017 and was undertaken in order to check how the provider had met its action plan. We had also received information of concern from an external source prior to this inspection and these concerns were looked into as part of the inspection. Following this visit we received other information of concern from other external sources. We returned unannounced to the service on 21 November 2017 to conduct a second day of this inspection and look into the additional concerns which had been brought to our attention.

At our previous comprehensive inspection on 30 January, 6 February and 16 March 2017 the service had an overall rating of Requires Improvement. We had rated Safe and Well-led as Requires Improvement and Effective, Caring and Responsive were rated as Good. This report only covers our findings in relation to specific aspects of Safe and Well-led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Angela House on our website at www.cqc.org.uk.

Angela House is registered to provide care and accommodation for up to a six adults with a learning disability or autistic spectrum disorder. At the time of this inspection there were five people living at the service, each with their own bedroom. The accommodation comprises a communal lounge, kitchen diner, a sensory room, a small rear courtyard, and communal bathrooms and toilets. The bedrooms do not have ensuite facilities. The house is located in a central part of Hammersmith close to a wide range of amenities, public transport and a large park.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 the time of the inspection the service was being managed by an experienced manager who had applied to the CQC for registered manager status.
At the previous inspection we had found that staffing levels did not demonstrate that sufficient staff were consistently deployed to ensure that people received their care and support in a timely manner. At this inspection we found that the staffing levels were now satisfactory. The staffing levels were planned in accordance with people's needs and kept under review.

The systems for storing medicines needed to be improved. Although the provider was aware that the temperature of the room used for the storage of medicines was not suitable for this purpose, no actions had been taken to address the problem. Concerns about how the service decanted medicines to the relatives of a person who regularly took breaks away from the service with their relatives were shared with us by the relatives. Although the relatives were offered an alternative system that would have been safer, the relatives were not consulted with or provided with sufficient training about the new medicines system so that they

could make an informed decision.

Although the health and safety records we checked were up to date, the cleanliness of the premises needed to be addressed. The structural damage at the service had resulted in the growth of mould in communal areas and we were informed after the inspection that this mould had spread to the bedroom of a person who uses the service.

Staff understood how to protect people from the risk of abuse and confirmed that they had received safeguarding training. Individual risk assessments had been developed in order to reduce identified risks to people's safety and welfare.

We received mixed feedback from relatives. It was evident that one person's relatives had concerns about how the service met their family member's personal care, health care and social needs and they were understandably frustrated that the provider had not implemented the improvements they sought. Another relative acknowledged that there were issues that impacted on Angela House and other care services, for example the difficulties with recruiting and retaining staff of a high calibre. This relative commented on areas that needed improvement such as the maintenance and refurbishment of the premises; however they were presently pleased with the quality of care and support provided to their family member. They felt that their concerns and queries were satisfactorily responded to by the provider.

The new manager was experienced and had received favourable feedback from health and social care professionals in regards to their approach and commitment to improving the service. At the previous inspection we had noted that staff had treated people with kindness and were caring, which we observed during the inspection. However, we had been made aware of an incident when people were not supported with compassion and afforded the privacy they required.

The issues of concern we identified at the inspection indicated that the provider's own quality monitoring and audits did not pick up on areas that needed improvement. For example an obsolete inspection report with a former rating was being displayed on a notice board on the first day of the inspection although the provider is required by legislation to ensure that the current rating is prominently displayed. We had also observed that a cupboard with hazardous domestic cleaning items was not locked as it did not have a complete lock attached.

We found two breaches of regulation in relation to the safe storage of medicines and the need for the service to receive more robust monitoring. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were now sufficient staff deployed at all times to ensure people's safety and meet their needs and wishes.

However, medicines were not consistently stored and managed in a safe way. Changes to the medicine system did not demonstrate consultation with relatives involved with supporting their family members to take their medicines.

Staff understood how to safeguard people from the risk of harm and abuse.

Risks assessments and accompanying guidance were in place to identify and mitigate risks to people's safety.

Safe was rated as Requires Improvement at the previous comprehensive inspection. We did not cover all aspects of this key question at this focussed responsive inspection. We will review the rating for Safe at the next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not demonstrate that the systems in place were sufficiently rigorous to assess, monitor and improve the quality of the service.

The views from relatives, health care professionals and staff about the leadership of the service was mixed. External professionals noted that some staff had been resistant to change and found that the manager strived to make improvements and introduce guidance from professionals.

There had been concerns at the service in relation to how people were supported to meet their needs and receive dignified support.

Well-Led was rated as Requires Improvement at the previous

comprehensive inspection. We did not cover all aspects of this key question at this focussed responsive inspection. We will review the rating for Well-Led at the next planned comprehensive inspection.

Angela House

Detailed findings

Background to this inspection

This inspection was done to check to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection completed on 16 March 2017 had been made The inspection was also carried out in order to look into concerns we had received about the quality of care and support and the management of the service. This inspection took place on 11 October and 21 November 2017 and both days were unannounced. The inspection team consisted of the lead inspector and a second adult social care inspector on the first day, and the lead inspector and a different adult social care inspector on the second day. The team inspected the service against two of the five questions we ask about services: Is the service safe? and Is the service well-led?

Before the inspection we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to CQC, information we had received from external sources and the report for the previous inspection that was carried out on 30 January, 6 February and 16 March 2017.

During the inspection we met and spoke with the five people living at the service. They were not able to tell us their views and experiences; therefore we observed how people interacted with staff and how they were supported by staff in communal areas. We spoke with four support workers, the manager, the deputy manager and the area manager. The records we looked at included two people's care and support plans, medicine records, accident and incident reports, health and safety documents for the premises, and the minutes for staff meetings.

We received comments about the quality of the service from the relatives of three people who use the service and two health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we had received information of concern regarding how the provider's use of agency staff had negatively impacted on the quality of care and support for people who use the service. An external health and social care professional had informed us that low staffing levels had caused problems with the effective application of professional guidelines, and a relative had told us about their concerns regarding the provider's ability to ensure that people received continuity of care from staff they were familiar with. We had observed that there were insufficient staff rostered on an evening shift in order to meet people's complex and high level of care needs.

At this inspection we looked at the rotas and shift plans for a two month period following the previous inspection. We noted that although staffing levels varied there were at least three staff on duty in the evenings apart from two occasions. We were informed that one of these occasions was due to a member of staff giving short notice of not being able to attend work due to unforeseen urgent circumstances. The manager informed us that there had been positive improvements in the wellbeing of a person who uses the service and the person no longer required the intensive level of support that staff provided at the time of the previous inspection. We looked at the person's care and support plan and found that their daily records of care demonstrated that their needs had changed in line with the observations reported to us by the manager.

We also checked the rotas and shift plans for 13 randomly chosen days in September and October 2017. We did not detect a widespread use of agency staff and found that there was typically a minimum of three staff on duty although sometimes there were seven or eight staff.

On the first day of the inspection we found that medicines were not being stored safely. The medicines cabinet had a thermometer which displayed minimum and maximum temperatures, and the temperature was recorded daily by staff. However, there was no guidance for staff to follow if temperatures were above the recommended temperature of 25 degrees Celsius. We noted from the provider's records that the temperature was regularly above 25 degrees and found that the temperature increased when the tumble dryer located next to the medicines cabinet was in use. We observed that the temperature had risen to 26.7 degrees after the tumble dryer had been in use for 35 minutes. We discussed this finding with the manager who advised us that they planned to move people's medicines to lockable cabinets in their bedrooms, as this would provide a cooler and more person-centred environment. On the second day of the inspection we found that the medicines were still stored next to the tumble dryer and the temperature checks showed average temperatures of 26 degrees. This was above most medicine manufacturers' storage recommendations, which meant the medicine was at potential risk of changing composition or deteriorating due to unsafe storage conditions. Following the inspection visits to the service, we have subsequently received information from the provider to inform us that individual medicine cabinets for three people who use the service had arrived and a larger medicines cabinet was now stored in the office.

On the first day of the inspection we checked the medicines for two people who use the service. We conducted counts of their medicines and checked that the correct balances were recorded on their

medicine administration record (MAR) charts. There were no gaps on the MAR charts we looked at. On the second day of the inspection we checked the medicine administration record (MAR) charts for two other people who use the service. We found that the MAR's had been correctly completed apart from one gap for a medicine that should have been administered on the previous day. The medicine still remained in the blister pack. We were unable to ascertain if there was a valid reason why the medicine had not been administered as there was no written entry by a staff member on the MAR chart, for example to state whether the person had refused their medicine or the omission of the dose had been advised by a health care professional. We discussed this finding with the area manager when they arrived at the service. The area manager explained that the manager checked the MAR charts on each shift they worked at the service in order to establish if there were any issues of concern or discrepancies. As the manager was not scheduled to work that day, the area manager confirmed that they would follow up this finding.

We received information from a relative who was concerned about how the service organised their family member's medicine for a weekend away at their family home. The relative raised a complaint as the medicines had been decanted into small bottles and envelopes, and there was insufficient information for relatives to safely follow. We were sent a copy of the complaint, which included photographs of how the 'take home' medicines had been arranged. We noted that there was a lack of written information to safely advice relatives to administer the medicines. The relative told us that the provider had changed their medicine system but this was not done following discussions with relatives, who were responsible for administering medicines when people were staying with their families.

We discussed this complaint with the manager who explained that the service had moved from having a medicine system arranged by time and day where all tablets were mixed together in a blister for each administration time to a new system with a separate 28 day blister pack for each medicine. The purpose of this change was to support staff to safely administer medicines, for example it was previously difficult for staff to ascertain which tablet was missing if a tablet was accidentally dropped. The manager stated that the decanting took place because a relative did not wish to use the blister packs. Although the changes were introduced to improve the overall safety of the provider's medicines system we noted that the lack of prior consultation with relatives and the insufficient level of written guidance for relatives about how to safely support people with medicines meant that people were placed at risk of medicine errors. This potentially could have been avoided if the transition period for changing the medicines system had included adequate time for relatives to discuss their views with the provider's management team and other relevant professionals, for example the provider's medicines trainer and/or a representative from the dispensing pharmacy.

Our findings about the lack of action to remedy the temperature for the room that medicines were stored in and the lack of effective planning to ensure the new medicines system was safely introduced to all relevant parties constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014.

On the first day of the inspection we observed that there was a COSHH (Control of Substances Hazardous to Health) cupboard in the laundry room with a lockable clasp; however this was not locked. We pointed this out to the deputy manager who was unable to locate a padlock for the cupboard and asked members of the staff team, who did not know either. Arrangements to ensure that the cupboard was locked were not implemented during our visit, although this was remedied on the second day of the inspection.

We observed that the premises did not look clean, particularly with regards to the routine cleaning of ceilings and walls. The extractor fans were dirty and potentially were not functioning properly as a result of this. There was a great deal of black mould on the external wall of the upstairs bathroom and a downstairs

bathroom also had a rotten panel next to the bath, although it did not appear to be a splinter hazard. We did not see any mould in the bedrooms that people who use the service permitted us to look in during the inspection but received anonymous information following the inspection which suggested that a bedroom was affected by the mould. These findings demonstrated that people were not consistently provided with a hygienic and comfortable living environment, although it is acknowledged that previous flood damage had caused fundamental problems. Other observations showed that rails were firmly attached to walls, and there were no loose carpets or evident trip hazards. The portable electrical appliances testing was up to date and other checks for hoists and power chairs were also up to date. We discussed these findings with the manager and the area manager on the first day of the inspection. On the second day of the inspection we noted the premises looked cleaner and we were informed that deep cleaning by an external contractor had been arranged. The area manager confirmed that the provider was still in the process of making structural improvements to the premises following significant physical damage that occurred in 2016.

We spoke with members of the staff team about their understanding of the actions they were required to take in order to keep people safe. Staff confirmed to us that they had received safeguarding training and they demonstrated their knowledge of how to identify different types of abuse and the procedures for reporting any concerns. Staff stated that they would contact external organisations such as the local learning disability team, the police and the Care Quality Commission if they felt their concerns about people's safety and welfare were not being taken seriously by the provider. Some members of staff expressed that they did not feel confident that the management team would appropriately respond to any issues they raised.

The two care and support plans we looked at contained individual risk assessments. These assessments identified the risk to the person using the service and/or others and gave guidance to staff about how to respond to and mitigate these risks. This included guidance to support people with behaviours that might challenge the service. Staff had attended training about how to de-escalate behaviour that may challenge the service and promote positive behaviours. The risk assessments had been written in a manner that promoted people's safety and where possible, safely promoted their choice and independence.

Requires Improvement

Is the service well-led?

Our findings

At the time of the previous inspection there was an interim manager in post, as the registered manager had not been carrying out the day to day management of the service since May 2016. The interim manager had a substantive post as the manager of a supported living scheme operated by the provider and worked at Angela House five days a week. Before this inspection we received confirmation from the provider that a new manager had commenced working at the service in September 2017 and the plan was for this manager to apply to the Care Quality Commission (CQC) for registered manager status. The manager had prior experience of working as a registered manager for the provider and had also been managing a supported living scheme operated by the provider for people with a learning disability or autistic spectrum disorder, before taking up their new role. We were informed by the area manager that the former interim manager who was in post at the time of the previous inspection had taken an unforeseen period of authorised leave and was due to return to Angela House a few days after the second day of the inspection, which would ensure that a member of the management team was rostered every day to support people who use the service and the staff team.

At the previous inspection we had been informed by the management team about the difficulties the provider had encountered with its attempts to appoint a deputy manager, as there was no deputy manager in post. We subsequently received news that the provider had made an appointment. On the first day of the inspection we met the relatively new deputy manager who told us they were soon leaving the care home. Following the second day of the inspection we received information from the manager to state that interviews had been conducted for the appointment of a new deputy manager but unfortunately a suitable candidate had decided not to take the offer of employment.

The relatives of three people who use the service provided their views about the quality of care and support provided to their family member. We received detailed and carefully considered information from all of the relatives. As people who use the service had resided there together for many years, relatives told us that they were keen to ensure that all people living at the service received the care and support they needed to meet their needs. The opinions and observations of the relatives were mixed. The relatives of one person were concerned that that the service was not able to safely and competently meet the needs of their family member. They had raised their concerns with the provider on several occasions and did not feel that improvements had been achieved. The relatives informed us that they had made arrangements for their family member to move to another service. We were informed of unacceptable observations they had made at the service, for example a person who uses the service had removed their clothes and was sitting next to a soiled incontinence pad in the communal lounge and another person had been left in a communal toilet with the door open. The relatives had a range of concerns which included changes in the way that the medicines were dispensed for administering when their family member was staying at their relatives' home, the support given to their family member for personal care and how the service cared for their family member when they had a period of ill-health.

The relative of another person who uses the service told us they were aware of concerns that had arisen at the service and had heard about the concerning observations made by another person's relative. This

relative told us they thought their family member was happy and well cared for. They were pleased with how the service liaised with health care professionals and supported their family member to meet their health care needs. The provider invited them to attend annual care planning and review meetings, which they enjoyed. They described staff as being friendly and chatty; staff spoke with them about the activities their family member was engaged in and kept the relative informed about any changes happening at the service. This communication included staff sending photographs to the relative of their family member taking part in outings and social events. The relative expressed that they were concerned about the structural problems that had occurred at the service and the length of time to resolve these issues had impacted on proposed plans for redecoration and refurbishment, which was now well overdue. The relative told us they spoke directly with the provider's senior management team if they had any concerns and had felt reassured by their investigations.

The relative of a third person told us that staff showed warmth and a caring approach towards their family member. They stated that their family member was supported to attend health care appointments and their medicines were regularly reviewed. Staff were described as having the skills and knowledge to provide the care their family member needed and staff understood how the family member's health care needs impacted on their daily routines. The relative informed us that they did have a concern about an incident and discussed this with the management team. The managers were described as being helpful and kept the relative informed of changes in regards to their family member's welfare and other more general changes, for example about the premises. The relative had observed that the care home was clean during their most recent visit.

Information from health and social care professionals demonstrated that there were some concerns about practices at the service. A health and social care professional told us that some of the staff had not been following health care guidelines and there was a lack of willingness from some of the staff to listen to or take on board professional advice. This was not an isolated view and was expressed by other parties. We received positive comments from health care professionals about the changes introduced by the new manager, who was reported to be a hard-working manager and had introduced some positive changes to ensure that professional guidelines were followed and a more person centred approach was promoted. The manager was supported by the provider to develop her management skills and attend management forums, which included presentations from external health and social care organisations. We were shown the agenda for a recent management group meeting and seminar, which featured a presentation about regulatory responsibilities.

We had noted at the previous inspection that the interim manager had not been able to provide staff with one to one formal supervision at least once every two months in line with the provider's own policy, although staff on their probationary period had received regular one to one sessions to support their development. At the previous inspection we had found that team meetings were taking place although the minutes we had looked at did not evidence monthly meetings, which used to be the frequency that staff were accustomed to. Staff and other external sources had reported to us that the staff team did not feel appropriately supported to undertake their roles and responsibilities.

At this inspection we found that some staff continued to not feel supported by the provider and felt that managerial changes had resulted in not enough supervision and guidance. Some staff voiced concerns about the current style of leadership and how the service was managed. For example, staff expressed that they needed additional training to produce electronic care plans and stated that there was an over reliance on frozen foods at the service, instead of cooking healthier meals with fresh ingredients. One member of staff felt that people who use the service would not require the same level of prescribed aperients if their diets contained more fresh fruits and vegetables. (These are medicines primarily used to relieve

constipation). Following the inspection visits, the provider has subsequently informed us that the management team promote the use of fresh foods, which has resulted in people reducing their clinical need for medicines to relieve constipation. Another member of staff told us that the quality of care and support had declined because the provider used agency staff who did not have the skills and knowledge to work at the service. Following the inspection visits, the provider has subsequently informed us that staff have been advised that they can directly contact agencies if a member of the management team is not on duty and they have concerns about the competency of an agency worker on duty at the service.

We had received information from staff and external sources that the provider had used agency staff who did not have moving and handling training and therefore had refused to assist staff with taking people out into the community in their wheelchairs. This concern was discussed with the area manager on the second day of the inspection, who demonstrated that the provider had used a reputable staffing bureau that supplied advance details of the relevant training and valid qualifications that agency staff had, so that the provider could determine if they were suitable to support people who use the service. The area manager advised us that the provider would not offer shifts to any agency staff who refused to or were not able to support people with their moving and positioning needs, if such concerns were brought to their attention. Other concerns included the deterioration in the condition of the premises following flood damage in 2016 and the provider's alleged failure to repair or replace a washing machine in a timely manner, taking into account that managing regular laundry requirements was vital in order to meet people's identified needs.

On the second day of the inspection we spoke with the area manager about how the provider endeavoured to support staff. The area manager told us about the meetings that had been conducted with staff and attended by her and other senior personnel from head office. We were shown the posters that staff had created about how to work together to develop and improve the service. The agenda for meetings showed that there had been discussions about communication and issues that had occurred in the past and the plans for the future. The area manager explained that staff working at the service were due to spend time shadowing colleagues at another local service operated by the provider. This care home had recently achieved positive outcomes for people who use the service, as demonstrated through its CQC inspection report and external recognition for good leadership in a national awards scheme for services for people with a learning disability. The area manager explained that the aim of this shadowing and mentoring programme was to introduce staff to working in a more person centred way as opposed to a task orientated approach.

Members of staff informed us that there had been an accident at the service two days before the second day of the inspection, as a person fell off a chair whilst having a meal. We looked for the accident form and could not locate it. The manager subsequently sent the accident form to us, which was dated nine days after the accident. Staff had expressed their concern to us that the CQC had not been notified. Upon receipt of the accident form we noted the event was not within the criteria for a statutory notification and saw that the local authority had been informed. However, we observed there was an unacceptable delay by the manager in completing the provider's accident form which did not appear consistent with the provider's own policies and procedures for promptly recording information relating to people's safety and wellbeing. During the inspection we looked at the accident and incident forms that had been completed since the previous inspection. These forms evidenced that appropriate actions had been taken after events, for example people were referred to their GP or a relevant health care professional and their relatives were informed. There was evidence that the provider reflected on the accident or incident to identify any learning to prevent a future reoccurrence.

There were systems in place to monitor the safety of the premises and audit the quality of care and support but the effectiveness of these checks was not clearly demonstrated. At the previous inspection we noted that the area manager was closely involved with supporting the management team at the service and staff,

particularly since there had been further changes that impacted on the stability of the service, for example the resignation of the deputy manager and a period of authorised leave for the former interim manager. We found that the provider's own checks were not picking up on issues that needed to be improved, such as the general hygiene of the premises and the lack of a functioning lock on the COSHH (Control of Substances Hazardous to Health) cupboard, which potentially placed people who use the service at risk. There had been no recent medicines audit by a pharmacist or relevant health care professional even though there were identified problems with regulating the temperature for the storage of medicines, three incidents which involved missed medicines had occurred since the previous inspection and a relative complained about the safety of the medicines system. We received information from the manager after the inspection to confirm that they had contacted the local dispensing pharmacist to arrange audits.

On the first day of the inspection we saw that there was a full copy of the inspection report for October 2014 displayed on a noticeboard in the communal kitchen and dining room. This did not comply with the regulation and the provider's legal duty to display their current overall rating, which was issued following the previous inspection which was completed in March 2017. We pointed this out to the deputy manager and this issue was rectified on the same day.

Prior to and after the first day of the inspection we were informed of events at the service that did not demonstrate that the service was well-led. This included accounts of chaotically delivered care, for example relatives finding that their family member had not been suitably supported with personal care for a weekend stay at their family home even though the staff knew the relative was arriving to collect their family member. We were informed by the provider that the incident where agency staff had not provided people with dignified care had occurred when the manager needed to be in the kitchen to sort out a delivery of medicines and was therefore not in a position to observe how the staff were meeting people's needs. Some members of staff and other sources informed us that this would not have happened if a permanent member of staff had been on duty, hence this was regarded as another example of the provider not ensuring that people received a calmly delivered and properly organised service. An external source informed us that they had made a complaint to the provider about this incident and other concerns but had not received a satisfactory response. We discussed this with the area manager and have requested a copy of the provider's complaint investigation response in order to review how the complaint was dealt with. We also were informed by external sources of an incident when a supermarket did not deliver the scheduled weekly shopping. The manager explained to us that when the shopping did not arrive and chasing up the matter by telephone did not produce a satisfactory response she went out and did the shopping herself. The manager stated that she did not want people who use the service to be subject to any additional delays or inconvenience whilst the supermarket investigated how the error had occurred and looked into the whereabouts of the order. Although this specific matter was due to circumstances beyond the control of the service, we understood why it had caused concern for relatives who heard some information about the event and feared that there was insufficient food available for their family member and other people living at the care home.

The provider's own quality monitoring had failed to identify some issues that need to be addressed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Registered Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure the proper and safe management of medicines. 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality checking arrangements did not consistently assess, improve, monitor and sustain the quality of experience for people who use the service. 17(1)(2)(a)