

Healthcare Homes (LSC) Limited

# Ashley Gardens Care Centre

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

# Summary of findings

## Overall summary

### About the service

Ashely Gardens Care Centre is a residential care home providing accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury to up to 89 people. The service provides support to older and younger adults with dementia needs. At the time of our inspection there were 87 people using the service.

Ashely Gardens Care Centre is a purpose-built care home which accommodates the people living there across three separate floors, each of which has separate adapted facilities. People had their own bedrooms and toilets there are shared bathrooms, eating and living spaces on each floor.

### People's experience of using this service and what we found

Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from abuse and improper treatment. People's medicine support was not being managed safely. There were not always enough staff to safely meet people's needs and some relatives raised concerns this could mean that their family member's needs may be neglected. The service was clean and hygienic and infection control measures were being managed to help prevent the spread of infection.

People's strengths, levels of independence, life histories, personal preferences, interests and quality of life was not always accounted for when planning and reviewing their care. The design of the service did not always meet people's dementia needs. People were offered support to take part in social activities inside and outside of the service, although this support was inconsistent. Activities were not available for people who were not able to leave their bedrooms, meaning there were risks they could become socially isolated. People had support to maintain relationships with families and friends. People's medical end of life care needs were met, to help them be as pain-free as possible.

We have made a recommendation to the provider about ensuring the environment of the service meets people's dementia needs.

Quality assurance and governance systems were not always effective in making sure risks to people's safety were identified and managed safely, people received good quality care or people's care records were accurate and up to date. Staff at all levels had not always been supported to understand and fulfil their expected roles and responsibilities. Staff gave mixed feedback about the culture of the service and did not always feel well-supported or listened to by managers. Some relatives told us they were happy with the support their family members received and that they had regular opportunities to give feedback about the service.

After our inspection, the manager gave immediate assurances about actions being planned and taken by staff in partnership with other health and social care professionals regarding risk management, fire safety and medicine issues we identified. This included submitting a plan of actions within 24 hours, along with

documentary evidence, telling CQC about actions they had or planned to take to ensure immediate risks of harm to people were reduced.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

The last rating for this service was good (published 28 September 2017).

#### Why we inspected

We undertook a targeted inspection to follow up on specific concerns about choking risks which we had received about the service. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with choking risks and risks to people with behaviours that may challenge, skin integrity, epilepsy, mobility support needs. We also found concerns related to fire safety, abuse and improper treatment, person-centred care, and governance. Due to this, we widened the scope of the inspection to become a focused inspection which included the key questions of safe, responsive, and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashley Gardens Care Centre on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding people from risks of abuse, staffing and governance at this inspection.

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

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

#### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

continue to monitor information we receive about the service, which will help inform when we next inspect.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate** ●

The service was not safe.

Details are in our safe findings below.

### Is the service responsive?

**Requires Improvement** ●

The service was not always responsive.

Details are in our responsive findings below.

### Is the service well-led?

**Requires Improvement** ●

The service was not always well-led.

Details are in our well-led findings below.

# Ashley Gardens Care Centre

## Detailed findings

### Background to this inspection

#### The inspection

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

#### Inspection team

This inspection was carried out by three inspectors and an assistant inspector.

#### Service and service type

Ashley Gardens Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashley Gardens Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Notice of inspection

This inspection was unannounced.

Inspection activity started on 23 February 2022 and ended on 8 March 2022. We visited the location's service on 23 and 24 February 2022.

#### What we did before the inspection

Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us by the provider since the last inspection and by the local authority and other agencies and health and social care professionals. This information helps support our inspections. We used all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection and last submitted a PIR in August 2021. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection-

We spoke with two people who used the service about their experience of the care provided. We spoke with eight support workers, six nurses, one health care practitioner, the deputy manager, the registered manager and the regional manager.

We used the Short Observational Framework for Inspection (SOFI) and spent time observing people. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included people's care and medication records and records relating to the management of the service. We looked at staff files in relation to recruitment and staff supervision.

After the inspection –

We continued to review care and management records and seek clarification from the provider to validate evidence found. We spoke with the registered manager via telephone. We spoke with and received feedback from two health and social care professionals who regularly worked with staff and people at the service. We spoke with seven relatives of people who lived at the service via telephone.

Due to the level of concerns we identified, we sought immediate assurances from the provider regarding actions being taken to reduce risk to people at the service.

# Is the service safe?

## Our findings

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

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

Assessing risk, safety monitoring and management, Learning lessons when things go wrong

- Risks to people's health and welfare were not always assessed, monitored and managed safely. People's risk assessments and care plans did not have enough detail about how to manage risks to their health and well-being safely. This increased the chance staff may not know how to support people to reduce or avoid risks to their health.
- There had been 34 reports of falls and 10 reports of skin injuries occurring in the period November 2021-February 2022. During the same period, there were 14 reports of behaviours that may physically challenge incidents involving different service users. During the period March 2021-February 2022 there were reports of three different people experiencing serious choking incidents when eating. Reviews of people's care records plans and risk assessments had not always been completed or changes made to people's risk assessments in response, to help keep people as safe as possible. This increased the risk these incidents would happen again.
- People who required food and fluid monitoring and weighing charts to check they were having enough to eat and drink were not being completed consistently, or at all, by staff. It was not possible to confirm if people had been supported as required to safely manage risks of dehydration, malnourishment or excessive weight gain.
- Staff were not aware of the safest way to reduce risks to people with choking and aspiration support needs. We spoke with 10 staff, including nurses, support workers and the management team who confirmed they were supporting people with these needs in inconsistent and unsafe ways. During our visits we observed staff not following agreed actions in people's risk assessments and care plans to reduce risks of choking or aspirating while they were being supported to eat, increasing the risk of harm to their health and well-being.
- Equipment used to support people to reduce choking and aspiration risks was not being effectively monitored or maintained. Amongst other uses, a suction machine on the ground floor was used to support people to remove food from their airway if they choked. The machine had not been checked regularly as per the provider's policy and we found it was not ready for immediate use in the event of an emergency. Suction machines were only available on two of the three floors in the service, although people living on all three floors were identified as being at high risk of choking. This increased the risk of avoidable delays to help prevent harm to people if they choked.
- Risks associated with people's behaviours that may challenge had not been assessed, monitored or managed safely. Staff were supporting one person with unauthorised physical and environmental restraint techniques. This support had not been risk assessed. Staff had not received training to know how to do this safely. This increased the risk of harm to the person, other people and staff.
- Staff were not completing the person's behaviour monitoring charts consistently. These charts were not checked by management to confirm if people were being supported safely and consistently if they displayed



behaviours that may challenge.

- We observed staff were not always following an agreed action in a person's risk assessment to provide 1:1 support when they were moving around the service. This increased the risk of the person physically harming themselves or other people.
- Fire safety risks were not being monitored and managed effectively. Fire safety checks were not being carried out in line with the requirements of the provider's Fire Safety Policy, increasing the chance equipment and alarm systems may not operate effectively to help prevent harm to people's well-being and health in the event of an emergency.
- All of the above issues were immediately fed back to the provider during our visits to ask them to act to address them.

#### Using medicines safely

- Medicines were not safely managed. People who had been prescribed 'as and when' (PRN) medicines for behaviours that may challenge, epilepsy and pain relief did not have adequate protocols or information in their care plans to direct staff about when and how to safely give people these medicines. This increased the risk people may be given medicines they did not need or may not have medicines when they needed them.
- Staff were administering a prescribed PRN medicine to a person daily, without recording the reasons why. Another person had been prescribed a variable dose of their PRN medicine, but staff were routinely giving the highest dose without recording the reason for doing this. Nursing staff responsible for the administration did not know if these practices had been agreed by a GP to check it was safe to do this. This was not being checked by senior staff or managers to make sure people were not at risk of harm to their health and well-being by being over-medicated unnecessarily.
- We observed nursing staff giving medicines much later than prescribed, increasing the risk they may not work as well. Nursing staff were seen to be dispensing multiple medicines and not signing to confirm people had received them until much later in the day. This increased the risk people may not receive their medicines as intended.

The provider had failed to assess, monitor and manage risks to service users' health and safety, provide safe care and treatment, manage medicines safely, ensure lessons were learnt or ensure staff had the right skills and experience to safely meet people's needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After our inspection, the manager gave immediate assurances about actions being planned and taken by staff in partnership with other health and social care professionals regarding risk management, fire safety and medicine issues we identified. This included submitting a plan of actions within 24 hours, along with documentary evidence, telling CQC about actions they had or planned to take to ensure immediate risks of harm to people were reduced.

#### Systems and processes to safeguard people from the risk of abuse

- Systems and processes to keep people safe from abuse and improper treatment were not operating effectively. During this inspection we identified risks, issues and concerns relating to safeguarding and neglect incidents had either not been reviewed or had not been adequately acted on by the provider regarding choking, behaviours that may challenge, personal care and skin integrity and falls.
- Between September 2021 and February 2022 there had been five safeguarding incidents concerning allegations of neglect and improper treatment of people raised by external healthcare professionals, as well as many internal reports of potential safeguarding incidents regarding choking, behaviours that may challenge, personal care and skin integrity and falls.
- Service wide actions about supporting all people with complex eating and drinking needs had been

developed in response to a serious safeguarding incident in November 2021. The incident had involved staff neglecting a person's eating and drinking support needs. We observed during our inspection these actions had not all been implemented or communicated effectively by management at the service, and staff were not following all of them when supporting people to eat.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Staffing and recruitment

- The service was experiencing on-going staffing vacancies. The provider told us they felt this was due to factors linked to the impact of the Covid-19 pandemic, including staff voluntarily leaving and general lack of applications for social care roles across the sector. This had resulted in there not always being enough support staff available to safely meet people's needs.
- Staff told us they did not always have time to be able to meet people's personal care needs due to there not being enough staff deployed. One staff said, "We haven't the time to spend with people, they must think we have forgotten them. We don't get to do the personal care".
- We observed people looking unkempt and unwashed. People's bath and shower records showed people had not received regular bath and showers. Another staff said "There are not enough staff, we can't give care properly. The pad needs to be changed and there are always wet". We saw one person had become incontinent and was not supported in a timely manner with personal care, until we alerted staff to this need. A relative told us they had raised concerns about their family member's personal care needs not being met.
- Rotas were not always managed safely. Although the provider used a dependency tool to help deploy enough staff, this system was not ensuring people's needs were met safely. One staff said, "We keep raising this (staffing levels) as there are not enough staff... We can't give people all the care we want to give." Another staff told us that there were often shifts where there were as little as two allocated staff on shifts where there should be five and they felt this was unsafe. On both days of our visit, we saw people waiting for long periods to be supported with eating and drinking as there were not enough staff around to support people.
- A relative told us, "There are not enough staff, especially to support people with eating and drinking. I am concerned my Dad has lost weight. I am also concerned that staff leave my Dad in bed all day instead of hoisting him into his wheelchair". Another relative told us they also had concerns about their not being enough staff available to encourage their family member to eat and drink when they needed it.
- Rotas were not managed to always ensure staff working on each floor had the right skills and qualifications to support people safely. Although all people living on the top floor of the service required nursing support, there were no nurses allocated to work on this floor. The healthcare practitioner responsible for overseeing people's nursing care on the top floor told us they were not on the nursing register as an associate nurse. They said they should be having clinical supervisions in their current role but they had not had one yet and it was overdue.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had systems in operation to help ensure safe recruitment practices. Pre-employment checks for potential new employees were carried out, to help prevent unsuitable staff from working in a care setting. This included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Staff also had to provide references and employment histories.

### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

### Visiting in care homes

- The provider was facilitating visits to people living at the home in accordance with current infection prevention and control guidance.

# Is the service responsive?

## Our findings

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

At our last inspection we rated this key question Outstanding. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences, End of life care and support, Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans lacked information and details regarding their life histories, important people in their lives, personal preferences and emotional and social needs, as well as their strengths and levels of independence. Care plans had not always been reviewed effectively to make sure they were comprehensive, accurate or up to date. This increased the chance that staff may not be responding in the best way to people's individual wants and needs, affecting their overall quality of life.
- People had been supported to develop end of life care plans. These lacked detail about their emotional and spiritual support needs and preferences as they were approaching the end of their life.
- The environment of the home did not always consider the individual needs of people living with dementia. Living areas within each floor of the service lacked accessible signs, objects of reference and personalised decoration to help people living with dementia feel at ease, make choices and move around the service as independently as possible.

We recommend the provider considers recent best practice guidance about personalising the service environment to meet the dementia needs of people living there.

- There were designated 'activity' support staff to help offer communal social activities to people, and a weekly activity schedule. Activities were not available for people who were not able to leave their bedrooms, meaning there were risks they could become socially isolated. One person said there was not always someone to chat to and when asked if there were enough activities said, "I get bored".

### Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The registered manager told us staff considered people's individual needs and communicated with people in ways they understood. We did not observe staff using accessible ways to communicate with people during our visits. The registered manager told us staff could adjust information to support people's communication preferences as and when this may be necessary. We were shown an example of a pictorial alphabet board staff used to have conversations with one person who did not communicate verbally.

- Communal activities offered to people at the service were limited in the extent they were personalised to people's individual needs and preferences, especially given the large number of people living at there. However, some routinely offered activity choices such as musical entertainment and exercise classes had been specifically designed to meet the needs of people living with dementia.
- We were shown examples of instances since the last inspection where staff had arranged for personalised activities for groups of people, or individuals which were specific to their preferences. This included swimming, eating out and taking part in community art competitions.
- People were supported to maintain contact with families and friends. Staff had arranged virtual and socially distanced visiting opportunities throughout the Covid-19 lockdowns in line with government guidance.
- The registered manager and staff had offered ways to ensure people had been able to access the wider community. This included support for people to go on a 'Daily Mile' walk into the nearby town.
- People did have designated pathways for arranging any necessary equipment and resources needed to support people approaching their end of life. A healthcare professional told us staff worked well with them to make sure these pathways were followed and people were kept as medically comfortable and pain free as possible.

#### Improving care quality in response to complaints or concerns

- The provider had a formal complaints policy to ensure any complaints were responded to in an open and transparent manner. The registered manager kept a monthly log of any complaints received and these were reviewed to help try and make sure all issues raised were resolved satisfactorily. A relative told me they had been satisfied with the response from staff when something had gone wrong for their family member.

# Is the service well-led?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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.

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

- Internal quality assurance systems and processes to audit or review service performance and the safety and quality of care were not operating effectively. There was a comprehensive and regular system of audits undertaken by staff at all levels within the provider's organisation. These had not always identified or prevented issues occurring or continuing at the service. For example, nurses, the registered manager and regional manager were not aware of issues in relation to risk management, medicines and fire safety.
- Where quality and safety issues had been identified, the registered manager and provider had not always overseen or acted to improve or resolve these. For example, actions to ensure people were kept safe from neglect and choking risks were not all being followed by staff. Where people's care plans had been reviewed and updated, they had continued to contain inaccurate and out of date information about how to safely meet people's needs.
- The provider's governance framework had not been effective in ensuring staff at all levels were aware of their responsibilities and that a good standard of care was sustained at the service and relevant legal requirements were met. At this inspection we found multiple breaches of regulations had occurred, placing people at actual and avoidable risk of harm to their health and well-being. Statutory notifications had not always been submitted as required by the registered manager.
- Some staff told us they didn't always feel supported by management to fulfil their responsibilities. One staff said "We have some support but sometimes we need new things. Our floor manager tries to get us some new wheelchairs and new beds. Some beds are breaking. Equipment isn't great."
- Staff, including those in specialised roles, told us they had only received on-line training about their role. One staff said they had received "inconsistent" support from their mentor, and they felt they should be better supported.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong, Working in partnership with others

- The registered manager had not always ensured they had shared information regarding safety incidents with external agencies, to help make sure there was an adequately informed review, investigation and actions agreed to help avoid or prevent these issues happening again.
- Staff had not ensured that all actions and recommendations identified by health and social care professionals to ensure people achieved good outcomes were communicated to and understood by all

staff.

The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved and the service worked in partnership effectively with other agencies is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- Some healthcare professionals told us staff were good at contacting them for advice and had worked well with them to help people when there had been safety incidents. The registered manager had begun a process to help make sure relatives were informed about incidents and accidents. A relative told us that staff had been informed them promptly when things had gone wrong with their family members support.

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

- The provider had developed a set of values they expected staff to embody when supporting people. The registered manager told us these included, "Being passionate, committed and respectful, and helping people to live in a dignified way as they choose". Staff received equality and diversity training to help them understand the importance of creating an open and positive culture where people's differences were respected. However, our findings at this inspection confirmed improvements were needed to ensure staff understood and displayed these values and training principles when carrying out their roles.
- We received mixed feedback from the staff we spoke with about the culture at the service. One staff said, "We don't see the manager much, sometimes she comes up at lunchtime". Another staff said, "Sometimes I feel supported, when we need a person or more staff. I don't think they (management) care enough".
- Other staff said they felt supported by the service management but although they had opportunities to raise feedback about improving the service, they didn't feel senior management listened. One staff said, "I don't feel valued at the moment. We don't get given any credit. We don't feel appreciated."
- The registered manager told us the provider supported staff equality and diversity. There were various employee reward and recognition schemes in operation, to help recognise staff achievements and improve staff morale. The provider offered staff access to an Employee Assistance programme which could provide external mental health and financial advice and support.
- The registered manager had held regular virtual meetings, sent out newsletters and maintained email contact with people's relatives throughout the pandemic to keep them up to date with service developments. Relatives were sent regular surveys to get their feedback about the service. Some people's relatives told us they had positive experiences when engaging with staff and the management. Other relatives told us they felt involved and included in their family members care and they thought staff and management were approachable and took on board their feedback.
- The registered manager told us they were looking to re-start ways of involving and engaging people in their support delivery that had been affected by the covid-19 pandemic and staffing shortages. They said, "We are looking to be innovative, trying to listen to people and understand what would make them happy".

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
Treatment of disease, disorder or injury	The provider had failed to assess, monitor and manage risks to service users' health and safety, provide safe care and treatment, manage medicines safely, ensure lessons were learnt or ensure staff had the right skills and experience to safely meet people's needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
Treatment of disease, disorder or injury	The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was



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

## Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

## Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.