Edgemont View Limited

Edgemont View Nursing Home

Inspection report

160 High Street
Oldland Common
Bristol
BS30 9TA

Tel: 01179077380

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 August 2016 and was unannounced. There were no concerns at the last inspection in May 2013. Edgemont View Nursing Home provides accommodation for up to 21 people. At the time of our visit there were 19 people living at the service.

There was a manager in post but they were not registered. 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.

Despite the views of people and their relatives, improvements were required in a number of areas. People were not protected from the risk of cross infection. This was because appropriate guidance had not been followed. People were not cared for in a clean, hygienic environment. Monitoring of the quality of the service was not always effective.

The manager and staff followed procedures which reduced the risk of people being harmed. Staff understood what constituted abuse and what action they should take if they suspected this had occurred. Medicines were managed safely and staff followed the services policy and procedures.

The provider's recruitment policy and practices helped to ensure that suitable staff were employed. The manager and staff were able to demonstrate there were sufficient numbers of staff with a complementary skill mix on each shift.

People moved into the service only when a full assessment had been completed and the manager was sure they could fully meet a person's needs. People's needs were assessed, monitored and evaluated. This ensured information and care records were up to date and reflected the support people wanted and required.

Staff had the knowledge and skills they needed to carry out their roles effectively. People were helped to exercise choices and control over their lives wherever possible. Where people lacked capacity to make decisions Mental Capacity Act (MCA) 2005 best interest decisions had been made. The Deprivation of Liberty Safeguards (DoLS) were understood by staff and appropriately implemented to ensure that people who could not make decisions for themselves were protected.

People received a varied nutritious diet, suited to individual preferences and requirements. Mealtimes were flexible and taken in a setting where people chose. Staff took prompt action when people required access to community services and expert treatment or advice.

References were made by relatives and staff about the 'family atmosphere and homely feel'. Staff were knowledgeable about people they supported and it was clear they had built up good relationships. Family

and friends had completed surveys this year and expressed their gratitude to staff and the services provided.

The manager had settled in to their role and had started to look at how they would continue to improve the service for people and staff. The service was important to them and they wanted the best for people. There was an emphasis on teamwork and unity amongst all staff at all levels.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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.

People were not protected from the risk of cross infection because appropriate guidance had not been followed. Some areas of the home were not clean and hygienic.

Staff had received training in safeguarding so they would recognise abuse and know what to do if they had any concerns.

People received care from staff who took steps to protect them from unnecessary harm. Risks had been appropriately assessed and staff had been provided with clear guidance on the management of identified risks.

There were enough staff on duty to support people safely.

People were protected through the homes recruitment procedures. These procedures helped ensure staff were suitable to work with vulnerable people.

People were protected against the risks associated with unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

People received care from staff who understood their needs and preferences. Staff were supported and keen to learn new skills and increase their knowledge and understanding,

Staff knew how to support people who were unable to make certain choices themselves, in line with the Mental Capacity Act 2005.

People were provided with a healthy diet which promoted their health and well-being and took into account their nutritional requirements and personal preferences.

The service recognised the importance of seeking advice from community health and social care professionals so that people's

health and wellbeing was promoted and protected.

Is the service caring?

Good

The service was caring.

People were supported by staff that were caring and kind. It was important to staff that people were happy and enjoyed living in the home.

Staff treated people with dignity, respect.

We saw examples of kindness, compassion and staff going that extra mile.

Is the service responsive?

Good

The service was responsive.

Staff identified how people wished to be supported so that it was meaningful and personalised.

People were encouraged to pursue personal interests and hobbies and to join in activities.

People were listened to and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Requires Improvement

The service was not always well led and improvements were required.

The provider and manager had not taken prompt action within their responsibilities under the conditions of registration with CQC.

Effective quality monitoring systems were not in place. Audits were not always being completed to regularly assess the quality and safety of the services provided.

People and staff felt supported by the manager.

Edgemont View 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This service was previously inspected in May 2013. At that time we found there were no breaches in regulations. This inspection took place on 9 August 2016 and was unannounced. One adult social care inspector carried out this inspection.

Prior to the inspection we looked at information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. We use the PIR to assist in our planning of the inspection.

During our visit we met everyone living in the home and spoke with five of those people. There were no relatives available for us to speak with at the time of inspection. However, we did look at all the feedback they had given in the compliments book and the surveys they had completed. We spent time with the manager, the nurse in charge, and three staff. On 10 August we telephoned and spoke with an additional member of staff who was responsible for training. We looked at four people's care records, together with other records relating to their care and the running of the service. This included four staff employment records, policies and procedures, audits and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. During our inspection we looked at the environment. People were not protected from the risks associated with cross infection because appropriate guidance had not been followed. The home was not clean in all areas. Bedrooms and communal areas were particularly dusty, cobwebs, dust and dead insects were in corners and under furniture. Staff used talcum powder and this had created a film of dust on people's personal belongings, floors, furniture and equipment such as commodes and hoists. It was evident some areas had not had a deep clean for some time. Although we were told that clutter had reduced around the home, there were still areas in the home where cleaning was not effective because of the clutter.

Some things were in poor repair and cleaning would be compromised, there was a risk that these areas could harbour germs. Laminate had peeled off vanity units exposing rough chipboard. We saw a raised toilet seat in one bathroom which was broken, the arms had fallen off and it was not fixed safely, someone had stuck duct tape over the front of the seat as a quick fix. We asked for the seat to be condemned.

Some people required the use of a hoist to be able to transfer safely. A sling fits to the hoisting equipment to allow the person to be hoisted safely and comfortably. Slings can vary in type and size to meet people's needs and they should have their own slings. Hoist slings were hung up in the communal hallways. Staff could not confirm if these had been used or were clean. Although we were told slings were for individual use we could not be satisfied that this was happening because they were not labelled with people's names. We found slings draped in bathrooms and on hoists but we couldn't identify who they belonged to and who has used them.

There were six hours deployed per day for domestic duties by two members of staff who worked from 9-12pm. There were no other hours deployed for any further cleaning from 12pm and deep cleaning of the home and equipment did not take place.

Infection control audits had not identified the issues we found and needed to be reviewed. The provider and manager were not following the Department of Health, Code of Practice on the prevention and control of infections, or other relevant guidance.

This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and protected. One person said, "It's reassuring having a nurse on duty". One relative recently wrote in their survey, "It is reassuring to see first-hand and realise how well my relative is looked after. I have no qualms whatsoever when leaving them in their care". People and staff were protected by the homes policy for entering the home. The front door was securely locked and visitors had to ring a bell to gain entry. All visitors were required to sign a book and state the reason for their visit and who they had come to see. Health and social care professionals were asked to show an official form of identification before entering the premises.

Staff understood what constituted abuse and the processes to follow in order to safeguard people in their care. Policies and procedures were available and training updates were attended to refresh their knowledge and understanding. The manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they notified included the local authority, CQC and the police.

Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Written accident and incident documentation contained a good level of detail including the lead up to events, what had happened and what action had been taken. Any injuries sustained were recorded on body maps and monitored for healing. There was evidence of learning from incidents that took place and appropriate changes were implemented.

Staff understood specific risks relating to people's health and well-being and how to respond to these. This included risks associated with weight loss and maintaining skin integrity. People's records provided staff with information about these risks and the action staff should take to reduce these. Examples of intervention the service had taken included a referral for specialist advice from a dietician and supplying specialised equipment such as pressure relieving aids.

The manager had implemented a new initiative to help protect people and staff from injury and or harm. The uniform policy had been reviewed and staff were checked at the start of their shift in order to ensure they were adhering to this. Staff were not allowed to wear jewellery or nail varnish and nails had to be short in length. Staff were reminded of the injuries people could sustain when receiving care such as skin tears and bruising. Correct foot wear had to be worn at all times to help reduce injury to staff when using moving and handing equipment, such hoists and wheelchairs.

Staffing levels were constantly reviewed to ensure they were effective and helped ensure people were safe. Levels were determined by the amount of support people required. The manager recognised where certain times of the day were particularly busy and people required more support. An extra care staff member was deployed from 9-11am to assist with people's personal care needs and breakfast. This was also applied form 3-8pm to assist with those who wanted support with their evening meal and to get ready for bed. Wherever possible and, if required an additional staff member was deployed to help at lunch time, especially if there was an increase in people requiring support with their meals.

Everyone we spoke with confirmed there were sufficient numbers of staff on duty 24 hours a day. People were able to request support by using a call bell system in their rooms and staff were available in communal areas of the home. During the inspection the atmosphere was calm and staff did not appear to be rushed, they responded promptly to people's requests for support. One relative recently wrote in a survey, "When I visit a calm atmosphere prevails which must be beneficial to the residents". The staffing levels did not alter if occupancy reduced. If people's needs increased in the short term due to illness or, in the longer term due to end of life care, the staffing levels were increased. Staff escorts were also provided for people when attending appointments for health check-ups and treatments. The manager ensured there was a suitable skill mix and experience during each shift.

Safe recruitment procedures were followed at all times. Appropriate pre-employment checks had been completed and written references were validated. Disclosure and Barring Service (DBS) checks had been carried out for all staff. A DBS check allows employers to check whether the applicant has had any past convictions that may prevent them from working with vulnerable people.

Policies, procedures, records and practices demonstrated medicines were managed safely. There had been

no significant errors involving medicines in the last 12 months. Nurses completed safe medicine administration training before they were able to support people with their medicines. They were observed on all medication rounds until they felt confident and competent to do this alone. Practical competency reviews were also completed with all nurses to ensure best practice was being followed.

Good

Is the service effective?

Our findings

Staff had the knowledge and skills they needed to carry out their roles effectively. They told us they enjoyed attending training sessions and sharing what they had learnt with colleagues. Care staff had completed nationally recognised qualifications in health and social care and others were in the process of completing these. Nurses were supported to update their skills and knowledge for the roles they performed. This included wound care management, diabetes and syringe driver updates. Syringe drivers were used to administer medicines continuously through a needle just under the skin. The manager and nurses were mindful to keep up to date with current best practice and guidance. They made provision to support each other with their duties and responsibilities to the National Midwifery Council (NMC) and revalidation. Revalidation exists to improve public protection by ensuring nurses continue to remain fit to practice in line with the requirements of professional registration, throughout their career.

We spoke with the lead staff member who was responsible for organising, accessing and monitoring training for all staff. In addition to mandatory courses this year staff had either completed or enrolled on courses for, dementia awareness and better outcomes for people, food allergies and intolerance, effective communication, person centred planning and dignity and respect. Following each course attended, staff were asked to reflect on the delivery of the training, the content, whether it was effective and what they had learnt to improve their practice. We were given examples where training had a positive impact and had resulted in better outcomes for people. For example, following the dementia awareness course the home had introduced coloured crockery and improved signage for those people with dementia. Staff told us they also had a greater understanding about behaviours for those people with dementia and better ways of supporting them should they become anxious or upset.

The service had a small, steadfast group of staff. Everyone felt supported on a daily basis by the manager, nurses and other colleagues. Additional support/supervision was provided on an individual basis. Staff liked the opportunity to talk about what was going well and where things could improve, they discussed individuals they cared for and any professional development and training they would like to explore. Everyone attended staff meetings as an additional support, where they shared their knowledge, ideas, views and experiences.

Communication systems were in place to help promote effective discussions between staff so that they were aware of any changes for people in their care. This included daily handovers, staff meetings and written daily records. These accounts also provided a good level of detail for all staff to read, they told a story and informed staff about what had happened during the month. This was particularly useful for those staff who had been absent during holiday leave or sickness absence. We sat in on a handover and found the information shared useful and informative. There was a positive group participation and discussion and staff were made fully aware of what duties were required during their shift. One staff member told us the handovers were a 'good way of ensuring a consistent approach to care and helped ensure things didn't get missed'.

All staff had received training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty

Safeguards (DoLS). The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions. The DoLS provide a legal framework that allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it was in their best interests to do so. Staff understood its principles and how to implement this should someone not have capacity and how to support best interest decisions. This included those decisions that would require a discussion with family, and possibly other significant people, for example health and social care professionals.

There was a clear account of why referrals had been made and how a person had been supported through the process and by whom. This included GP's, best interest assessors and or independent advocates. There were systems in place to alert staff as to when DoLs would expire and need to be re-applied for. There was one person where a DoLS had been authorised at the time of our inspection.

There were no restrictive practices and daily routines were flexible and centred around personal choices and preferences. People were moving freely around their home, socialising together and with staff and visitors. They chose to spend time in the lounge, conservatory, the dining room, their own rooms and gardens. People also went out independently or with staff and family members.

People were happy with the quality and variety of the food. We observed people enjoyed their meal at lunchtime. Those that required assistance were being supported respectfully and at their own pace. Staff were attentive throughout lunch offering drinks, help and a second helping. We read written compliments from people about the food which included, "I absolutely love the food, compliments to the chef" and, "It's lovely how the cook presents dinner so beautifully, and blended food is always served in separate portions, lovely colours, just as it should be".

We met with the cook who was very knowledgeable about the people living in the home, their likes dislikes and dietary requirements. They met with people on admission and held meetings with everyone to discuss menu changes and any requests. Recently people had asked for pork pies, more fruit cake and gin and tonic. This had been actioned by the cook. In addition to the routine drinks and snack rounds, we were told beverages and snacks were available to people throughout the day, including fruit salads, crisps and biscuits.

If people were at risk of weight loss a screening tool provided guidelines to assist with developing a care plan and identifying any action required. Food and fluid intake was recorded if required, so that any poor intake would be identified and monitored. People were weighed monthly but this would increase if people were considered at risk. Referrals had been made to specialist advisors when required, including speech and language therapy when swallow was compromised and, GP's and dieticians when there were concerns regarding people's food intake and their weight.

Good

Is the service caring?

Our findings

The service was caring. We were introduced to people during our visit and we spent time observing them in their home. The atmosphere was relaxed and people appeared comfortable and confident in their surroundings. People told us they were 'happy and looked after well'. One person said, "I couldn't be happier, everyone cares about me and they all do their very best". Written comments received in surveys included, "The entire staff ooze with love and really care for those lucky souls in their charge", "To date my relative has been overwhelmed by the real care and attention she has the joy to experience from all staff" and, "I feel mum is very well looked after in every way".

We read compliments that people living in the home had made about individual staff. Staff were referred to as 'angels and little gems' and, 'really nice and very warm'. An agency nurse had recently covered a shift and left a compliment in the book. They wrote, "I couldn't believe how friendly staff were, they were very cheerful and interacted well with residents, it was a lovely atmosphere to work in".

We asked staff what they thought they did well and what they were proud of. Comments included, "We are always here to help them but it's equally important that we also support what they can do for themselves and not take away their independence", "Respecting people as individuals and making sure their choices and preferences are respected" and, "It's all the little things, the time we spend with them, our approach and making them feel special". One relative had recently sent a thank you cared to staff which read, "Since moving in my relative has seemed happier than they have been in a long while. His general attitude to life has improved and he seems very settled, thank you for all you have done it's such a weight off our minds".

During our visits we saw staff demonstrating acts of patience and kindness. Mealtimes were a good example where staff promoted an atmosphere that was calm and conducive to dining. We observed staff speak sensitively to people, they described the meal they served, repeatedly offered drinks and asked if everything was satisfactory. People who required help with eating and drinking were supported with dignity and respect. One staff member was assisting a gentleman with their meal, they asked the person if they wanted their clothes protected and they replied 'yes'. The clothes protector was made of cloth and the design was a man's shirt, tie and waistcoat. This was a positive way of protecting people's clothes from spillage without the person feeling undignified or childlike.

There were some lovely examples of staff supporting people to maintain their existing relationships with people important to them. One person wanted to attend their granddaughters wedding. Staff took the person shopping for their wedding outfit and a staff member offered support by attending the wedding with the person. One staff member told us they 'couldn't wait to see the photographs'. They also told us about how they had taken a 'resident on regular trips to the hospital to visit their loved one who was unwell'.

There was an ethos of an extended family within the home. Relatives always felt welcome and the manager told us that many relatives continued to visit the home even when their loved ones had passed away. One relative was now a regular volunteer. On the day of our visit the manager and several staff members were attending a funeral for a person they had recently lost. The staff were very touched when they returned and

it was evident that they had been very fond of the person and, had forged good relationships with the family. Their dedication and care had been acknowledged at the funeral.

One person had recently reluctantly moved from the home because they wanted to be near friends, their church and in an area they had lived in for over 50 years. The family wrote their thanks and gratitude to the staff and said, "It is with heavy heart we are moving mum, we would like to thank you for your professionalism, patience and support and for taking such good care of her".

Good

Is the service responsive?

Our findings

All staff were responsive to people's health and well-being, they were observant, knew people well and identified when they may be feeling poorly or 'out of sorts'. On the morning of our visit staff were concerned about one person who seemed unusually sleepy and difficult to rouse, staff immediately sought the support of the nurse on duty who promptly attended the scene in the lounge. Thankfully the person was in a very deep sleep and gently came round with a gentle touch from the nurse. This person had diabetes and staff had not had problems waking this person from a 'nap' before now. The nurse carried out observations such as blood pressure and pulse and everything was satisfactory. The person went on to have a good day with no other problems.

The manager and nurse spoke with us about a person whose health had recently, rapidly deteriorated and was subsequently admitted to hospital as an emergency. Nurses had the skills and competence to recognise when medical attention was required. Later the family had written to the manager and said, "The prompt action of your staff saved his life".

The manager or nurses completed an assessment for those people who were considering moving to the service. Every effort was made to ensure that significant people were also part of the assessment including family, hospital staff, GP's and social workers. Pre-admission information gathered was used to develop care plans based on the individual needs and personal preferences; they were reviewed and further developed during the first four weeks of admission. People and their relatives were supported through this process by the manager, nurses and care staff.

Information was fairly personalised but the manager had identified that improvements were required to further enhance a person centred approach. This did not mean that people were not receiving care and support that respected their wishes, but the records could reflect this more effectively. Staff we spoke with described what was a 'typical day' for people, including from the time they got up from the time they went to bed. People had established their own set routines and staff respected these.

We met with the activity coordinator. People were offered and provided with a range of activities, outings and things of interest. They handpicked what they liked to do or take part in. Activities were always included on the agenda at the 'residents' meetings. They took ownership about preferred interests and hobbies and were encouraged to express, discuss and share new ideas. Particular favourites for people included arts and crafts, board and card games, reminiscence, bingo and quizzes. People also had personal ways they liked to relax for example, knitting, sewing, light gardening and receiving daily newspapers.

Some people were able to go out independently, families and friends also went out with their loved ones and staff supported as escorts where required. People enjoyed small trips to local shops, cafes, parks and site seeing in Bristol and Weston-Super-Mare. Many people liked one to one interaction with staff and volunteers, the cook also worked additional hours to support this activity.

People invited their family and friends to social events, these were welcomed and attendance was very

popular. One relative wrote in their recent survey of their thanks to the activity coordinator, "There is no end to your talents and you have done a wonderful job with the display board".

The service had a complaints and comments policy in place and this was shared with people and families on admission. The daily presence of the manager and nurses meant people were seen every day and asked how they were. This approach had helped form relationships with people where they felt confident to express their views. Small things that had worried people or made them unhappy were documented in the daily records and gave clear accounts of any concerns raised, how they were dealt with and communicated to staff. This information was also shared with staff in shift handovers. One person wrote in their recent survey, "I have no complaints; everyone is doing an excellent job".

Requires Improvement

Is the service well-led?

Our findings

The service has a condition of registration that there must be a manager registered with the CQC, and an application must be made to the CQC as soon as they are carrying on a regulated activity. Although the manager had been appointed CQC had not received an application. The provider had not followed a formal system through supervisions/discussion with the manager where future plans should have been discussed and whereby registration was implemented in a timely manner. It was however, acknowledged that the application for the manager to register with CQC had been slightly delayed due to problems with personal identification documents.

The service was not always well led and improvements were required. Although the service was monitored by completing audits, some were not detailed enough. Infection control and environmental audits were not completed and the manager and provider had not recognised the risks that we identified during this inspection. Some audits help to assess and monitor the safety of the services provided. For example, there were good systems to record accident and incidents but, these were not audited. There was no evidence of learning from incidents that took place, so that appropriate changes could be implemented. Audits would have helped identify any trends to help ensure further reoccurrences were prevented.

The provider visited the home but did not complete a formal audit and they did not capture where improvements were required. Their visits needed to be more robust in order to support people who used the services. Often during their visits they would rely on hearsay rather than checking things out for themselves. Auditing of the service and facilities was not effective or sufficient. During their visits the provider was not actively seeking the views of people, relatives, staff, visiting professionals or commissioners about their experience and the quality of care delivered by the service.

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

Some audits were being completed by the manager and these had proved useful in order to improve effective record keeping and safe management of medicines. The care documentation audits provided nurses with very clear details of any omissions, out of date information and where more information was required.

One way the manager assessed the quality of services was by providing people and their relative's surveys to complete every year. People were positive about the home and the service provided. One person wrote, "I have full confidence in the way the home is run". The manager spoke with us about how they had taken action following requests and suggestions. Some people had commented on the lack of ironing and that people's clothes were sometimes creased. Extra hours had been deployed for more ironing and this had been received well.

Staff felt supported by the manager and enjoyed working at the home with fellow colleagues. Comments included, "The manager is very good, if I need anything she is very quick to respond", "We are a good team

with a nice mix of ages and experience" and, "We all work well together and that helps a lot, it's a nice place to work and we have a sense of pride in how we care for people".

The manager was knowledgeable about the people in their care, the policies and procedures of the service and they were confident to share with us their views, aims and objectives. They shared new initiatives and 'plans for the future' in the PIR and we spoke with them about this during our visit. Plans included, on the spot checks of the environment, introduction of the new care certificate for induction of new staff, a new improved supervision programme, increasing the frequency of resident and relative meetings and the introduction of 'bitesize' teaching sessions.

The manager promoted and encouraged open communication amongst everyone who used the service. There were good relationships between people, relatives and staff, and this supported good communication on a day to day basis. Other methods of communication included meetings for people, their relatives and staff. The minutes of the meetings gave details about what was discussed and provided information of any action that was required.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with cross infection and appropriate guidance had not been sought or followed. Regulation 12 (2) (h)

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	Regulation 17 HSCA RA Regulations 2014 Good governance Systems did not drive improvement in the quality and safety in some of the services provided, particularly around the infection control and the environment. Regulation 17 (2) (b)