Platinum Care Homes (Stanwell) Limited

Church View Care Home

Inspection report

Falcon Drive
Stanwell
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TW19 7EU

Tel: 01784248610

Date of inspection visit:
18 January 2021

Date of publication:
19 March 2021

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

Summary of findings

Overall summary

About the service
Church View Care Home is a care home providing personal and nursing care for up to 78 people. The service is provided in one adapted building which is divided into six wings, each with its own lounge and dining area. At the time of our inspection, 55 people were living at the service over six wings.

People's experience of using this service and what we found
Risks associated with people's care were not always being managed in a safe way, including infection control practices and the management of medicine. Appropriate action was not always taken to reduce the risk of accidents and incidents reoccurring.

There were not always enough staff deployed at the service which left people at risk. This also meant staff were not always able to spend meaningful time with people. We have made a recommendation around this. Complaints were not always recorded and investigated appropriately.

Quality assurance was not always effective. Where shortfalls in care had been identified with staff, this had not been addressed robustly. The leadership needed to be more effective in ensuring staff were able to deliver the most appropriate care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We observed kind and gently interactions from staff with people.

We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well-Led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

Rating at last inspection (and update)

The last rating for this service was Requires Improvement (published 22 January 2020). Since this rating was awarded the registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

This service was registered with us on 4 March 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the infection control practices and the management of risks associated with people's care. A decision was made for us to inspect and examine those risks.

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 coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Church View Care Home on our website at www.cqc.org.uk.

Enforcement

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 have identified breaches in relation to the safety of care for people including infection control practices and medicines, the management of complaints and quality assurance.

For requirement actions or enforcement which we are able to publish at the time of the report being published. Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring 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.

Church View Care Home

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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Our inspection was completed by three inspectors.

Service and service type
Church View Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. On the day of the inspection the registered manager was absent from the home however we were supported by the assistant manager and provider.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with eight people who used the service about their experience of the care provided. We spoke with 13 members of staff including the provider, assistant manager, a nurse, care staff and ancillary staff.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at five staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received feedback from one professional who regularly visited the service and spoke with 13 relatives.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

- Risk associated with people's care was not always managed in a safe way. One person's care plan stated they were at high risk of choking and needed to be at a 90-degree angle when eating. However, we saw a member of staff supporting the person to eat and they had not been moved to a safe position to eat their meal.
- We noted another person's legs were swollen. They were sitting in their wheelchair in their room with their feet propped on a small stool which was not elevating their feet. They told us they needed to have their feet elevated and could do this when they were in their recliner chair. Their care plan stated they needed to have their feet elevated however there was no additional information as why this was, and we saw this was not taking place. Another person's care plan stated they had depression. However, there was no additional information on how staff needed to support this person.
- Where accidents and incidents occurred, steps were not always taken to prevent further occurrences and sufficient detail of the incidents was not recorded. For example, it was recorded on an incident form that on two occasions on the same day a person displayed aggressive behaviour. It was not clear whether this behaviour was directed towards people. The record stated that 'high level intervention was required' however there was no information on what this was. The person's care plan did not have any risk assessment in relation to any behaviour that may be challenging.
- Although the incidents and accidents were analysed, insufficient steps were taken to reduce the frequency of incidents of torn skin. Between October and December 2020 there had been six occasions where staff had identified skin tears on people. Although the follow up actions were to supervise staff moving and handling, additional training for them had not been considered to reduce further occurrences. After the inspection the registered manager confirmed that staff will have further training on completing the accident and incident reports and that actions taken as a result of incidents will be reviewed by the registered manager.
- The management of medicines was not always being undertaken in a safe way. People's medicines were recorded in a medicines administration record (MAR) with a dated photograph of the person and details of allergies. However, where people were being administered medicine by applying a patch, staff were not always recording on a body map where the patch was last applied. Staff should record the application of a patch and include the specific location so other staff can check that the patch is still in place and to ensure the patch is applied in a different area.
- On two occasions, in the morning and in the afternoon, we saw the medicine trolley had been left unattended in the corridor with the keys left in which meant there was a risk that people could access the medicines. The provider told us they frequently saw this happening yet sufficient action had not been taken to address this.

● There was also a gap on one person's medicine administration record (MAR) in relation to their blood-thinning medicine.

The failure to always manage risks associated with people's care in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were aspects of risk management that were safe. For example, there were mobility risk assessments in place. Where people required walking aids, we saw these were with the person. Care plans stated that staff were to ensure the area, particularly the person's room, was clutter-free and to keep reminding people to use their walking aids. One relative said, "They encourage [family member] to hold on to his standing frame." Where people required frequent repositioning in bed, we saw from records this was taking place.
● There was clinical care provided to people that was appropriate to their needs. For example, where wounds had been identified, regular photographs were taken of the wound to track the progress. We identified that pressure ulcers were healing as a result of the intervention from the staff. One relative said, "(The family member) can get uncomfortable in her chair so staff know when it's time to transfer back to bed. Also, staff know to turn her regularly."

Preventing and controlling infection
● At the time of the inspection, the service had a Coronavirus (COVID-19) outbreak however we found people were not being appropriately protected against the risk of transmission. People that had the virus had signs on their door with information on how long they needed to be isolated. However, their bedroom doors were left open as standard practice which put other people at risk of getting the infection. Prior to the inspection these concerns were also raised with us by a visiting health care professional.
● Staff did not always have access to adequate PPE when they exited people's rooms. In the corridors outside people's rooms there were tables that were intended to have PPE for staff to don and doff. However, there was limited supply of PPE on the tables. Some had only a pack of wipes, other tables only had a roll of aprons. This meant that staff at times were having to leave the floor to get fresh PPE.
● Staff were not always adhering to infection control practices in the appropriate way. We saw occasions where staff had the mask underneath their nose.
● Whilst there were areas that were clean and tidy this was not consistent. We found one person's bed bumper worn and dirty and the sluice rooms were not always clean. In one room the bathroom had a bedpan which was dirty. The straps on the commode situated over the person's toilet in the bathroom were dirty and their sponge on the basin was stained.
● People who had tested positive for COVID-19 were on each floor and all units, there was no zoning in place to minimise transmission of the virus.

The failure to manage infection, prevention control in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Immediately after the inspection we asked the provider to take immediate action to address the concerns around the management of infection control. They confirmed they had put systems in place to improve their practices.
● We were assured that the provider was accessing testing for people using the service and staff. We have also signposted the provider to resources to develop their approach.

Staffing and recruitment
● There were mixed responses from people relating to whether they felt there were enough staff. One person told us, "Staff come reasonably quickly." Another person said, "I have to wait sometimes too long for

someone to help me stand up and then again for someone to help me up off the toilet". Other comments included, "We could do with one or two more staff" and, "Most of the time there are enough. They do come quite quickly if I use the call bell." A relative said, "I feel they could do more nurses and carers." Another said, "Staff do not have enough time to spend with people."

● We considered the impact of the current COVID 19 outbreak on staffing levels and how the provider was managing this. Agency care staff had been rostered on to support and we saw that people were being supported in their rooms when needed. However, there were over 40 people on two separate floors that had nursing needs. We saw that only one nurse had been rostered on to support these people. A member of staff told us, "I try and see my people and give them care. We do resident of the day, but I can't be everywhere." Another member of staff told us, "Every care home is having difficulty at the moment because of the pandemic. But they do okay here for staff." The provider told us that two nurses should have been scheduled to work and was not aware that this had reduced.

● We asked the provider to send us in details of audits they had taken around the call bell response times. Although they sent us electronic records of call bells used in November and December 2020, these had not been analysed to check that people were responded to in an appropriate time.

● The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the Disclosure and Barring Service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people who use health and social care services.

We recommend the provider ensures there are sufficient staff deployed at the service to ensure that people's needs are met when needed.

Systems and processes to safeguard people from the risk of abuse

● People told us that they felt safe at the service. One person told us, "Staff are quite nice." Relatives fed back that they were confident their family members were safe with staff. Comments included, "I feel she's safe; the girls look after her", "I feel mum is safe and looked after" and, "As far as the home goes, she is safe."

● Staff had safeguarding training and said that they knew to report any concerns to the registered manager. They said they had confidence the registered manager would take action to address their concerns.

● The registered manager investigated safeguarding concerns raised and reported incidents to the local authority appropriately.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People and relatives fed back they felt staff at the service were competent in their role. Comments included, "Staff seem good, I think they are competent", "Staff are competent and very good and take care of (family member's) health needs", "They seem to be well trained and very supportive" and, "Staff are competent, you don't have to worry about that."
- Staff told us they felt supported in their role and had access to training. One member of staff told us that although they were not permanent staff, "The manager here would ask all staff to attend training." The member of staff said they received regular supervisions with the manager and could raise any concerns, difficulties or issues they were having. One relative said, "If someone is new or agency, another staff member would show them."
- Staff were provided with an induction before they started work. One told us, "I was shown around the building and given an introduction to the residents on the unit I would be working on."
- We reviewed the training records for staff and noted that all staff had received their mandatory training.

Supporting people to eat and drink enough to maintain a balanced diet

- People fed back that they were happy with the meals on offer at the service. One person said, "The food is reasonably good, and you get a choice." Another said, "It's alright. There are bound to be things you don't like. There are alternatives." Comments from relatives included, "Nice regular routine as far as meals" and "There is plenty of food."
- We saw during lunchtime that people were offered a choice of meal. People in their rooms were provided meals quickly. Those people that required support to eat their meal were provided this by staff. A member of staff told us, "They all choose what they want, and we just take it round."
- Staff were aware of people that were nutritionally at risk and took steps to address this. For example, if people were on a food and fluid charts if they were losing weight, guidance was sought from health care professionals where needed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff worked well with healthcare professionals to provide the most effective care. There was regular contact with the GP and the community nursing team. One healthcare professional told us, "The nurses are often helpful, and I often speak with the same nurse each time I visit."
- Staff had a handover at the end of each shift to share information about people's up to date needs. They also had Head of Department meetings each day where changes to people's needs were discussed and any

updates or daily events were shared.
● Relatives shared with us they were informed of any health concerns with their loved ones. A relative said, "The nurse rang to advise a course of antibiotics recently, it's nice to know."

Adapting service, design, decoration to meet people's needs
● The environment was adapted to meet people's needs. Comments from relatives Included, "(Family member) has a nice room, overlooks the garden, personalised the room" and, "Nice rooms on ground floor with garden access."
● The corridors and rooms were spacious to allow people to move freely. Furniture was arranged in small sections to encourage socialisation for when people were in the communal areas. The garden was well maintained and had a ramp for wheelchair users. One relative said, " There are photos in her room, made her room homely and personalised."
● There were signs on communal doors, including the bathroom and toilets, to help orientate people who were living with dementia.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● During the inspection we saw staff ask people for consent before they delivered any care.
● Staff had received MCA training and were familiar with what they needed to do if they believed people were lacking capacity to make decisions.
● Where people's capacity was in doubt mental capacity assessments were completed and these were specific to the particular decisions that needed to be made. For example, in relation to receiving care, having medicine and having bedrails.
● We also saw applications had been submitted to the local authority where the registered manager believed that people's liberties may need to be restricted for their safety.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed before they moved in. This was to ensure that staff knew the service could meet their needs.
●The assessments included information about communication, allergies, medical background, mobility, memory and cognition. Information from the pre-admission assessment was then used to develop care plans for people.
● Staff used recognised good practice and national tools to ensure that people's care was provided appropriately. For example, staff used a 'Waterlow pressure ulcer risk assessment tool' to review the risk of

developing pressure ulcers. There was evidence in care plans that staff used NICE guidance to assist them with care for example in relation to moving and handling.

Good

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The interactions we observed between staff and people were kind and staff spoke to people in a gentle and calming way. However, staff were busy on the day of the inspection and had little time to spend with people in their rooms. When staff were supporting people with their meals, they were not always interacting with them. We did feed this back to the assistant manager who told us they would address this.
- People fed back that staff were kind and caring to them. One person said, "Staff are very nice, helpful and caring." Another told us, "I do like them (staff). They are nice people." Relatives' comments included, "Staff nice, very pleasant", "Very supportive and understanding", "People (staff) are lovely, give her sweets and extra jam."
- Relatives told us about the importance of the video calls with family members during the lockdown. One told us, "(Staff member) will talk and try and encourage him during a video call, say, who's that?" Another relative told us on video calls staff, "Always say hello and goodbye. I like the way staff are cheery."

Supporting people to express their views and be involved in making decisions about their care

- People told us they had choices around their care including when they wanted to get up and whether they wanted a shower or a bath. One person said, "I have a shower most mornings."
- People were able to personalise their room with their own furniture and personal items and each room was homely and individual to the people who lived there.
- There was evidence in the care plans that people were asked what care they wanted and asked what their preferred routines were.

Respecting and promoting people's privacy, dignity and independence

- People and relatives told us that staff were respectful. Comments included, "They (staff) close doors and ask me to pop out while they are supporting mum, they keep her covered up", "Their (staff) touch is gentle, always kind and respectful" and, "They do show respect, always courteous to (family member), called by his first name." They told us this was preferred by their family member.
- When staff provided personal care to people, this was provided behind closed doors to protect people's dignity. We observed staff knock on people's doors before they entered. When staff spoke with people, they did this in a polite and respectful manner.
- Staff encouraged people to do things rather than assume they could not do them. During lunch, people were encouraged to eat independently where possible.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- Relatives fed back they did not always feel their complaints were investigated and were not informed of any outcome. One relative told us when asked if they felt complaints were listened to, "Unfortunately no to the outcome of previous issues." Another told us, "I have had a couple (of complaints), they haven't given many updates."
- Complaints were not always investigated and responded to appropriately. We were aware of complaints that had been made to the service prior our inspection. These complaints had not been recorded and there was no information recorded of the response. The service policy stated that complaints would be recorded, investigated with a response provided within 21 days. We found this was not taking place.
- People and relatives were not always provided with information on how they could make a complaint. One relative said, "Would not know what to expect and how to make formal complaint."

As complaints were not always recorded, investigated and proportionate action taken this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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

- Care records had information about people's care and support. For example, where people had diabetes there was information available to all staff about the monitoring of whether their blood sugar levels were too high or too low. Staff were knowledgeable about people's care needs.
- People fed back that activities were lacking but also acknowledged they understood they had reduced whilst people were isolating in their rooms. One person said, "There are no activities, but I do enjoy them when they are on." A relative told us, "It would be good for staff to have more hands-on time with residents and spend time with them."

End of life care and support

- End of life care was planned around people's wishes. Care plans contained information on people's spiritual and emotional needs and who people wanted to be with them nearing the end of their life.

Requires Improvement

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

- There were mixed responses from people about the management of the service. One person said, "(Registered manager) is doing her best under difficult circumstances. Every now and again I see the manager." Another person said, "There is a woman who walks around in a dark blue suit. Maybe that's her."
- There were also mixed views from relatives. One told us, "I would just like a quicker response to any emails" and another said, "I am phoning multiple times and not getting anywhere." Another told us, "There is a barrier to getting information." However other comments from relatives included, "To me it seems to be well-managed" and, "I know the manager and we get on well together. If anything, you don't like you only need to mention it and that's all done."
- Staff we spoke with on the whole were positive about the leadership at the service with one member of saying, "Her (the registered manager) biggest strength is how she approaches people. Staff find her supportive." However, another member of staff fed back that they felt the registered manager was not as 'hands on' as they would have liked.
- Prior to the inspection we were made aware of a coroner's investigation relating to a person that had lived at the service who had passed away. On the conclusion of the investigation it had been identified that improvements were needed around the care delivery and recording of information from care staff. However, no contact had been made to the relatives to apologise for the shortfalls. The Duty of Candour regulations set out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The oversight of the service was not effective in ensuring the quality of records and care being provided. The care plans did not always contain accurate and up to date information on people's needs. For example, in the care plans we looked at it stated, "I am unable to use my call bell system to seek assistance from staff." However, this was not the case for all of these people who were able to use their call bell. The fire folder on one of the floors listed two people who were no longer living at the service.
- Weekly meetings were taking place with staff and included reminders to staff on wearing their PPE appropriately and cleanliness at the service. However, visiting healthcare professionals identified concerns

around this which we also confirmed during our inspection.
● During and after the inspection we asked for the audits undertaken by the provider however we have not received these. This was despite the provider telling us they were visiting the home frequently and had picked up on staff at times leaving the keys in the medicine trolley. On the day of the inspection the provider was asked to feedback on how they were going to address the concern with only one nurse being on duty. We have not received any information from them relating to this.
● There were mixed responses from relatives about whether they felt engaged and involved in their family members care. One relative told us, "I've not had an update recently on his review of care needs." Another told us, "In the past, we had meetings to review care and support - they do involve me." A third relative said, "I would very much like to be involved in monthly reviews regarding our mother."

As quality checks and leadership were not always robust or effective this was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were elements to the quality assurance system that were effective. There were regular fire evacuation discussions with staff and health and safety checks ensured the safety and suitability of the building and grounds.
● Staff had regular meetings to talk through polices and updates on training.
● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events including incidents and safeguarding concerns.

Working in partnership with others
● The registered manager and staff worked with external organisations that regularly supported the service. This included staff from the local health centre and the local authority. One healthcare professional fed back to the service they received information about people prior to visiting.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were always receiving safe care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured that complaints were always recorded, investigated and responded to

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that quality checks and leadership was always robust