Wilson Care Resources Limited

Wilson Lodge

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection was undertaken on 01 and 08 December 2015. At our last inspection we identified that the registered provider was not consistently meeting the needs of people, and action was required to improve this situation. Following the inspection we met with the registered provider. They provided a written action plan and engaged consultants to help with the development of the service. This inspection found that significant improvements had been made, and further developments had been planned. However the registered provider was still not providing a service that was consistently safe, effective, caring, responsive or well led.

Wilson Lodge is registered to provide accommodation and nursing care for to up to 36 adults who are experiencing enduring mental ill health. At the time of our inspection 29 people were using the service. The registered provider had recruited a new registered manager since our last inspection, and they had commenced working at the home in January 2015 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.

Summary of findings

People living at Wilson Lodge were not always safe. Incidents of unsettled behaviour when people had upset or harmed each other had not always been identified as 'safeguarding' matters, and this meant people did not always get the support they needed, or that the relevant organisations and people were informed.

People had not always been supported to move safely, and manual handling techniques that could cause people harm, and compromise their dignity were observed during the inspection.

People whose medicines were administered from a pre-packed dosette could be confident they would get all their prescribed medicines in the correct dose. People who needed creams and tablets administered straight out of a bottle or packet could not be certain these would be administered as prescribed.

People were supported by adequate numbers of staff, who had been trained to meet the needs of people they were supporting and about how to work safely. Checks were made on new staff before they were offered a position at the home, and new staff received induction to ensure they were confident and able to meet people's needs.

People were offered nutritious food that was home cooked. People told us they mainly liked the food served. People did not have free access to drinks or snacks, and sometimes the gaps between meals for people who were unable to go out from the home to purchase snacks and drinks were too long.

People who were at risk of malnutrition were regularly weighed, but action was not taken promptly when their weight changed. People who had been assessed as needing extra food to help maintain their body weight did not always receive this.

People were supported to see a wide range of health and social care professionals. People's health care conditions were not always well managed by the nursing staff, and records did not show they had always been updated or reviewed when people's needs changed.

Individual staff showed kindness and compassion to the people they were supporting. However the routines and everyday practice in the home did not consistently value, empower or enable people.

The registered manager provided regular opportunities for people to provide feedback about their experiences of the service and to make suggestions for improvements or developments. Both discussions with people and records we viewed showed that this feedback was used in developing the service further.

People told us that they had been provided with new opportunities to undertake activities in the home and the local community. Our observations and discussions with people identified that these opportunities were isolated and that for most people, for large parts of each day there were no interesting or stimulating things to do.

The registered manager had a clear vision about how to develop the service. Feedback from people using the service, staff and visitors was positive about the registered manager's attitude and practice. We had lots of feedback that supported our findings that this is a developing and improving service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Systems and staff practices that were designed to reduce the risk of harm to people were not always effective.

Most people received the medicines they had been prescribed, but medicines that were administered directly from a box or bottle had not been well managed.

People were supported by suitable staff that had been trained.

Requires improvement

Is the service effective?
The service was not consistently effective.

The service was not always effective. When people lacked mental capacity the provider had not always identified how staff were to support them to make decisions about their everyday care.

Most people had good food that they enjoyed. However people at risk of malnutrition and dehydration were not always given enough food and drinks to maintain their well-being.

Staff had the skills and knowledge needed to meet most people's care needs, but people with complex health needs did not consistently get the support they required.

Requires improvement

Is the service caring?
The service was not consistently caring.

People were mainly supported by individual staff that showed kindness and compassion to them.

Routines and common practice in the home did not consistently value, empower or enable people.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People were supported by staff who knew them well.

People did not have regular access to activities and opportunities that would provide stimulation or protect them from social isolation.

People were supported to express any concerns and when necessary, the provider took appropriate action.

Requires improvement

Is the service well-led?
The service was not consistently well led.

Requires improvement

Summary of findings

The registered manager had a clear vision of how they wanted to support the people who used the service. There was a plan about how the service needed to continue to develop and improve.

Systems to monitor the quality of the service were not effective. There was not a well-developed understanding of equality, diversity and human rights and there were few examples of good practice in these areas.

Wilson Lodge

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 01 and 08 December 2015.

On the first day three inspectors undertook the visit, and on the second day two inspectors completed this visit.

Prior to the inspection we looked at the information we already had about this provider. We also spoke with service commissioners (people who purchase care and support from this service on behalf of people who live in this home) to obtain their views.

Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. Appropriate notifications had been sent by the registered provider.

All this information was used to plan what areas we were going to focus on during the inspection.

During the inspection we met and spoke with twenty of the people who were receiving support and care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We spoke with four relatives of people living at the home and spoke at length with seven members of staff and the registered manager.

We spent time observing day to day life and the support people were offered. We looked at some records including parts of six people's care plans and medication administration records to see if people were receiving the care they needed. We sampled staff files including the recruitment process. We sampled records about training plans, resident and staff meetings, and sampled the registered provider's quality assurance and audit records to see how the manager or provider monitored the quality of the service.

Requires improvement

Is the service safe?

Our findings

We last inspected this service in November 2014. At that time we found the registered provider was not consistently protecting people or ensuring that people were as safe as possible. Following the inspection we met with the registered providers who informed us of the action they would take. This included buying in specialist support from management consultants and developing an action plan. We found that these actions had been partially effective, some improvements had been made, and further improvements had been planned. However our inspection identified that the people currently living at Wilson Lodge were not always safe.

Everyone living at Wilson Lodge required the nursing staff to support them with the safe management of their medicines. We looked at the medicines management for five people. People whose medicines had not been pre-packed by the chemist could not be certain they would always get the medicines they required. Our audits and the records maintained by the home did not tally, and we found evidence that suggested people may have received either too much or too little of their prescribed medicines. Some people had been prescribed creams for sore skin. The cream had not always been written onto the Medicine Administration Record (MAR) and we found tubes of cream that had not been opened or used despite it still being required. Some people had needs that meant they required medicines 'when required' (PRN) There were not always guidelines available to support when and how these medicines should be given. This could result in them being administered inconsistently by different members of nursing staff. Medicines were not consistently well managed and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection the registered manager showed us the work undertaken to improve the administration of creams and boxed tablets.

We found that the medicines that had been pre-packed by the supplying pharmacy were being well managed. Records and our audits showed these were being given as the Doctor had prescribed. We asked people if they were happy with the support given to them with their medicines. People told us they were. One person told us, "We get our medication okay, but I'd like more water. If we have to have creams done we get taken to our bedroom." Another person praised the way staff worked at her speed, and another person told us staff always supplied plenty of water. Nursing staff had developed medicine information sheets for each person. These were a good way of ensuring people received their medicines in the way that they preferred and were a way of reducing the risk of medicines errors.

We asked people if they felt safe living at Wilson Lodge. Some people described feeling frightened when people shouted or hit out. Two people described being frightened by the unpredictable nature of some of the people they were living with. One person told us, "Sometimes people shout and swear. I don't like it." We asked people how staff helped them. Two people told us that staff only helped by administering tablets. Other people told us they did feel safe, and their comments included, "I don't feel worried about being shouted at or hit." During our inspection we observed two incidents between people living at the home. In both instances one person physically struck the other person. In one incident prompt action was taken to reassure and support the people involved. In the other incident the people were not offered reassurance, first aid or support until a significant time after the event. Although the registered manager recorded both incidents on their internal system, neither incident was identified as being 'safeguarding', and no multi agency alert was made until the inspector requested this be undertaken. On the second day of our inspection we looked at the work undertaken to review and update the support plan and relevant records following the incident which had occurred seven days earlier. We found that staff knowledge about the incident was variable; staff were not consistent in describing the action they would take to support the person or protect other people in the home. We found that known triggers to the unsettled behaviour had increased and that some of the previously effective risk management strategies were no longer possible. Neither staff knowledge and practice nor the supporting records had been updated to reflect the potential increase in risks. This left the person at risk of not receiving the care and support they required and left other people in the home at risk of being harmed. Failing to protect people from the risk of abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some people living at Wilson Lodge required the support of staff or of a mechanical hoist to help them stand and

Requires improvement

Is the service safe?

mobilise. We observed three separate occasions when the support given by staff did not meet recommended good practice guidelines. The techniques used had been proven to potentially cause harm to both the member of staff and the person being supported to move. Although staff had received training in safe manual handling techniques this knowledge was not being applied in practice.This meant that people were not being supported in a way that ensured their safety .This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

As we entered the home and moved around during our inspection, it became clear that not all areas of the home had been effectively cleaned or maintained. In some areas there was an unpleasant smell and in other areas of the home we observed that the floors, surfaces and furniture had not all been adequately maintained or cleaned. We brought this to the attention of the manager and provider who took prompt action to ensure that the situation improved as far as was possible. They informed us of further action they would take to ensure a longer term solution to the effective cleaning of the home. People we spoke with had mixed feelings about the standards of cleanliness. Some people told us that the men's toilets were "disgusting" and described the flooring in some parts of the home as "dangerous". An unpleasant smell was evident on the first floor of the home. We were told, "It always smells up here." Other people told us they were "proud" of their room and one person told us the home was kept "spotlessly clean." Failing to maintain the premises in a condition that is clean and well maintained is a breach of the Health and Social Care Act 2008. Regulation 15.

In the past people living at Wilson Lodge could not be confident that their money would be well managed. We looked at the action taken by the registered provider to improve upon this. The work had been undertaken to a good standard and new systems and controls had been put in place to ensure people's money was secure and that clear accurate records about money were maintained. People we spoke with confirmed this and told us, "I feel that my money is safe. I have bought my own chair and watch my TV in my room," and another person told us "We had a nice meal out for [name of person's] birthday, we get our money okay and buy our things." Discussions with the registered manager and provider provided further evidence of the work undertaken to ensure that people's money was safe.

Requires improvement

Is the service effective?

Our findings

We last inspected this service in November 2014. At that time we found the operation of the home was not consistently protecting people or ensuring that people were as safe as possible. Following the inspection we met with the registered providers who informed us of the action they would take. This included buying in specialist support from management consultants and developing an action plan. We found that these actions had been partially effective, some improvements had been made and further improvements had been planned. However our inspection identified that people currently living at Wilson Lodge were not consistently receiving an effective service.

Some of the people using the service had needs that required staff to apply the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We spoke with both the manager and the assistant manager who told us that they had not completed any assessments of capacity of people. However, we were advised that appropriate applications for authority had been made to restrict the liberty and protect the rights of people in specific or certain circumstances.

The manager told us that on occasion relatives gave authorisation for various things such as how many cigarettes a person could smoke. This was not done in a way that followed the appropriate legal process as specified in the Mental Capacity Act 2005.

During our observations and conversations with people we found that many of the bedroom doors were locked. Staff told us this was to protect people's belongings, from other people that might enter the room and take them. People had not all been offered the opportunity to have a key, or to manage their key in such a way as to promote their freedom. People told us, "I've got a key to my room, but it's in my room" and "I did have a key but I lost it." We explored when the key had been lost, and established it was a significant time ago. No replacement had been provided. The manager told us that most bedrooms were locked most of the time for safety reasons. Some people's wardrobes were locked, and staff held keys for these. There was no evidence that the correct legal process had been followed to ensure that the practice of locking doors was the least restrictive option and that people were not being unduly deprived of accessing their bedrooms when they wished.

These issues meant that people were not receiving person centred care appropriate to their needs and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people at Wilson Lodge were at risk of not having enough to eat or drink. During our observations we saw people sleep for long periods of time and miss out on opportunities to have a drink and to eat their meal. Although meals were saved for people there wasn't always evidence that these meals were later offered or that the person ate them. We looked in detail at the food and drink offered to and consumed by two people that our observations identified to be at risk. Neither staff practice or the provider's own records about what the people had eaten and had to drink in the week of our inspection showed that these people had consumed enough food or drink to stay healthy. These people had been regularly weighed and records showed they had lost weight and their weight was below the expected range for good health. Staff had not arranged for the people to be reviewed by a doctor or dietician. We looked at the support given to a person who had recently lost weight following a period of ill health. The person's weight records showed they were also below the average weight for a person of a similar height. None of these people had been offered a fortified diet or been encouraged to eat or drink additional foods to help increase their weight. At lunch time we saw that one person was given a meal that they did not enjoy and they ate very little of it. The person was not assisted or encouraged to eat more. The meal was removed and no alternative was offered. The person was then given a bowl of fruit which they ate with relish. They were not offered any additional fruit. We looked at the care records and saw that the person had been identified as needing extra nutrition to maintain their health. Failing to offer adequate nutrition or hydration to maintain good health is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they enjoyed their meals and comments included, "It is alright-you can't grumble about the food here", "We get to suggest what meals we like at the residents' meeting. Usually I get food I like every day", and "It's okay here. I think the food is quite good. You get a choice of food and a vegetarian option. Sometimes the soup is a bit cold. The cook asks us what we want to eat each day. We have a cooked breakfast on a Thursday and a sausage sandwich on a Saturday, because we can't have

Requires improvement

Is the service effective?

too much fat." Members of staff comments included: "The food and drink is very good" however we were also informed of the following, "I've noticed that people are hungry, some people snack when they are out. We discourage people snacking to keep their appetite." A person living at Wilson Lodge told us, "We only get a drink in the morning and the afternoon and cake on a Friday. We get supper and biscuits at 8pm and hot chocolate at 9.30pm"

We observed that when people needed help to eat and drink staff supported them kindly and at a pace that suited them. People had access to plate guards and specialist cups when these were required. There were dedicated kitchen staff who were knowledgeable about the preferences of people. We observed that people had opportunity to choose between two main meals each day, and that these meals were cooked from fresh using nutritious ingredients.

One person had recently been taken to hospital after a fall and from records we saw that appropriate action had been taken to ensure that the person had good access to appropriate healthcare support. One person's representative informed us of the general improvement in the overall well-being of the person they supported in recent months. The person felt the improvement was due to a general improvement in the running of the home and opportunities that had been made available to the person.

Staff we met told us they felt well supported, and that they had been trained in all the areas they required to effectively support the people living at Wilson Lodge. Comments from staff included, "We have really good supervision and support. All the nurses will help you if you need it", "I felt prepared and ready to start work after the induction" and "The manager is literally always asking us if we are alright and if we need anything."

Requires improvement

Is the service caring?

Our findings

We last inspected this service in November 2014. At that time we found the registered provider was not consistently providing people with a caring service. Following the inspection we met with the registered providers who informed us of the action they would take. This included buying in specialist support from management consultants and developing an action plan. We found that these actions had been partially effective, some improvements had been made, and further improvements had been planned. This inspection identified that people currently living at Wilson Lodge were still not consistently receiving a caring service.

People all told us that the staff at Wilson Lodge were kind and caring. Comments from people included, "The people are very kind. Even the cleaning staff and the cook are very kind" another person in the conversation said "I agree." Another person told us ""The staff are kind generally. It's very nice here." Another person told us, "[name of staff] is perfect to me. My best friend." Throughout our observations we saw many examples of individual staff demonstrating kindness in their day-to-day support of people.

However we also observed, heard and were informed about incidents and events where both individual staff and the 'regime' of the home failed to recognise the individual rights and needs of people. Examples of this included the lack of meals that reflected the cultural and religious diversity of people. We were informed that all the meat used was Halal. No alternative was available for people of other faiths or cultures. We observed and overheard interactions where staff failed to uphold the rights of people. Staff did not consistently value people's rights to make decisions. People talked to us about 'rules', and we heard staff telling people that certain choices were "not allowed." On numerous occasions people were referred to as patients. We heard a member of staff ask the assistant manager if a person was 'allowed' lunch as they had eaten earlier in the day. The person had requested lunch. This conversation was conducted in public and concluded with the manager giving permission for the person to eat. The person was not respected in relation to their choices about food and their dignity was not protected as the conversation took place in public.

During our inspection we observed people who had been incontinent and who required the help of staff to support them change their clothes. Staff were not quick to notice this need and on two occasions inspectors had to request help for people. We did not find that people consistently received the help they needed to maintain and protect their dignity.

There were two shared bedrooms still in use at Wilson Lodge. The registered manager told us plans were in place to phase out the use of these rooms out, to ensure everyone had a single bedroom. People we spoke with who shared a room were happy with the current arrangements. We found that dividing curtains had been provided in shared rooms between beds but these could be seen through and were not long enough to effectively protect people's privacy.

People told us that sometimes they ran out of clothes when the laundry got behind and that their clothes sometimes got mixed up. Comments included, "The laundry is okay but sometimes we do get other people's clothes." On the second day of inspection we observed that some people were not fully dressed. Staff and people we spoke with explained this was because of a problem with the laundry, and that some people had run out of socks and underwear.

During our discussions with people, staff and our observation of the running of the home we identified that while no individual members of staff were lacking in kindness or compassion some day to day routines and practices in the home were outdated and inappropriate. We discussed this with the provider and manager who were receptive of this feedback and in agreement that it needed to change. Failing to ensure that people received care and support that met their preferences and needs as individuals is a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

We last inspected this service in November 2014. At that time we found the registered provider was not consistently providing people with a responsive service. Following the inspection we met with the registered providers who informed us of the action they would take. This included buying in specialist support from management consultants and developing an action plan. We found that these actions had been partially effective; some improvements had been made, and further improvements had been planned. However our inspection identified that people currently living at Wilson Lodge were still not consistently receiving a responsive service.

People told us that the number of opportunities to go out and undertake activities in the local community had improved. While these opportunities were positive, we found that for most people their day to day lives lacked structure and the opportunity to undertake activities that they would enjoy or find stimulating. We asked one person about their day and they told us, "I'm bored." We explored with the person and staff the opportunities available, and these were limited to watching television or talking with other people. Some people found engaging in activities difficult due to their ill health. Opportunities for these people were especially limited, and our observations showed these people often slept for long periods each day.

People had regular opportunities to meet with the registered manager and senior staff. This provided a chance to raise ideas and give feedback. People told us they enjoyed this and one person told us, "There's a residents' meeting once a month and we always discuss food and activities. I don't think there's anything that needs to get better." A member of staff told us, "The residents chair their own meeting and we invite the relatives." The notes of the meetings showed that an honest and challenging conversation could be had, and that action was taken in response to people's suggestions.

The home had a 'Grumbles Book' which the manager told us was used to record minor complaints. We saw that any concerns raised in the book or any that had been raised as an official complaint had been responded to appropriately and in a timely manner. The manager was aware of the potential benefits of analysing trends or themes of complaints, and explained they hoped to start this shortly.

Requires improvement

Is the service well-led?

Our findings

We last inspected this service in November 2014. At that time we found the registered provider was not consistently providing people with a well-led service. Following the inspection we met with the registered providers who informed us of the action they would take. This included buying in specialist support from management consultants and developing an action plan. We found that these actions had been partially effective, some improvements had been made, and further improvements had been planned. However our inspection identified that people currently living at Wilson Lodge were still not consistently benefitting from a well led service.

The systems in place to assess, monitor and improve the home were not wholly effective and had failed to identify and address some of the issues revealed during the inspection which impacted on the quality of the service provided. Some of the omissions in systems, training, care practice or records that had not been identified placed people at risk

People we met had a wide range of both physical and psychological health care needs. We tracked the support given to people to meet specific assessed health needs. One person had been assessed as being at high risk of developing sore skin. Action had been taken to provide a suitable mattress for the person's bed but we observed the person sitting for long periods of time in a chair without any pressure reducing cushion in place. Although the person had not developed sore skin their healthcare needs relating to this risk had not been well met. It had not been identified that there no specific assessments or plans were in place to support the person.

We tracked the support given to another person who had recently moved into the home. Staff we spoke with had some knowledge of the person from the assessment completed before the person moved into the home, but no care plans or risk assessments were in place for staff at Wilson Lodge to ensure the person's needs would be met, and risks effectively managed.

The lack of effective systems to assess manage and improve the service provided is a breach of Regulation 17, of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection provided evidence that this was a developing and improving service. Many changes had taken place since our last inspection, and we were informed of further work that was planned or under consideration. People we spoke with made a number of comments which included: "There's something in the new regime that is improving things. [Name of person] is going out more and doing more. Under the old regime something wasn't right. In the last few months things have improved a lot. There is integrity in the home I feel." Another person said "People can relax and chill. The owners are really friendly and you get what you ask for," and another person said "The director is great and the manager is friendly, he's happy and gives 100% to the job."

The registered manager had undertaken a survey of the experiences of people living at Wilson Lodge. This had been well received and people had given constructive and helpful comments and suggestions about the running of the home. The registered manager was able to show what he had done with this information to further develop the service.

All of the staff, the registered manager and provider spoke about differences between the ways the two staff teams operated and related with people. Comments from staff included, "It's a bit fragmented between the shifts" and "The two teams work really differently. If you come tomorrow you will see and feel some significant differences in the way the shift is run." The registered person's had failed to address the differences that people experienced in day to care and support they received. Indications that the home was not consistently run had not been followed up or explored to ensure that any impact on people from the different styles from staff was not negative.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The registered manager had ensured that effective notification systems were in place and staff had the knowledge and resources to do this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 People could not be confident their medicines would be consistently well managed. People were not always supported to move using techniques that maintained their safety or protected their dignity. People had not always received the support they required to meet their healthcare needs.

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 Risks to people's safety had not always been identified. All possible action was not always taken to protect people from the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People did not live in premises that were clean and well maintained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People at risk of dehydration and malnutrition had not always received the support they required to ensure they had adequate amounts to eat and drink.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not consistently receiving care that was appropriate, that was meeting their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems in place to assess manage and improve the service were not effective and had failed to identify areas in need of attention or improvement.