Larchwood Care Homes (South) Limited

Wickwar

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**

Summary of findings

Overall summary

This inspection took place on 14 and 16 November and was unannounced. The nursing home is registered to provide a service for up to 39 people. At the time of our visits there were 22 people living at the service.

At our last inspection we rated the service good. At this inspection we found evidence that this was no longer the case and that the service required improvement. We brought this inspection forward because we had received information that suggested standards had deteriorated. Two visiting health care professionals had contacted us with their concerns and told us some staff who worked at the home did not think the service was meeting the current rating of Good awarded in December 2017. In addition, we received information from a whistle-blower and relatives who also expressed concerns. This inspection report will evidence and focus on areas that compromise the safety and quality for people who use the service.

The manager in post had worked at the home since April 2018 and had applied to CQC to be the registered manager. Their application was being processed by CQC registration at the time of this inspection.
Why the service was rated Requires Improvement.

A number of improvements were required to ensure people were kept safe and received quality care. The arrangements in place to ensure the service was well led from provider level down were unsatisfactory. Monitoring the quality of the service was not robust enough to ensure quality and safety. The manager lacked knowledge and understanding about their legal obligations.

We could not be satisfied that staffing levels and routines would keep people safe. Medicines were not always managed safely. 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. Parts of the environment still required improvement. We could not be satisfied that induction for new staff was effective.

People did not consistently receive person centred care and respect and dignity was not always promoted and practiced. Activities and people's emotional and psychological well-being required improvement. Staff were knowledgeable about people's lives before they started using the service. Improvements were required to enhance this knowledge so that their life experiences remained meaningful.

Checks were carried out on staff before they started work to assess their suitability to support vulnerable people. Staff received supervision and training required to meet people's needs.

Arrangements were made for people to see a GP and other healthcare professionals when they needed to do so. The registered manager and staff understood the principles of the Mental Capacity Act (MCA) 2005. People were supported to enjoy a healthy, nutritious, balanced diet whilst promoting and respecting choice.

We were introduced to people throughout our visit and they welcomed us. They were relaxed, comfortable and confident in their home. The feedback we received from them was positive. Those people who used the service spoke well of all staff.

Further information is in the detailed findings below.

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 has deteriorated to Requires Improvement.

Requires Improvement

Is the service effective?

The service has deteriorated to Requires Improvement.

Requires Improvement

Is the service caring?

The service has deteriorated to Requires Improvement.

Requires Improvement

Is the service responsive?

The service has deteriorated to Requires Improvement.

Requires Improvement

Is the service well-led?

The service has deteriorated to Requires Improvement.

Requires Improvement

Wickwar

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.

The inspection was carried out by one inspector for adult social care. An expert by experience joined us on the first day of our inspection. An expert by experience is a person who has used this type of service in the past.

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.

During our visit, we observed people living in the home and we spoke individually with 10 people. One relative was happy to speak with us and share their thoughts about the home. We spent time with the manager, a clinical nurse lead and a nurse. We spoke individually with seven care staff, the housekeeper, two domestics and the chef. Two healthcare professionals had contacted us prior to the inspection. In addition, we had received information of concern from a family and an anonymous whistle-blower.
We looked at five 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. Nurses and permanent care staff told us people were not always safe. We could not be satisfied that staffing levels on all shifts kept people safe. The current staffing levels did not consider staff break times, emergencies, those people who required two staff for personal care, moving and handling, meeting continence needs, ensuring adequate diet and fluid intake and to monitor communal areas. The provider used a tool to determine staffing ratio to people, but it was not fit for its intended purpose and did not consider the above factors and the logistics/geography of the home.

We were told by staff that things had recently got worse because routines had been changed with regards to who served food at mealtimes. Previously this had been overseen by the kitchen assistants and the care staff were responsible for ensuring people had adequate food and fluid by assisting them at each mealtime. Care staff were now responsible for serving all meals at each sitting which meant they were taken away from care duties. This had impacted on people waiting for personal care and continence needs. On the first day of our inspection three people were still not washed and dressed by lunchtime.

One staff member told us, "I worry about people when I go home, one shift last week we were unable to check people's continence pads before lunch because we had run out of time. We had to serve dinner and assist those people who could not eat independently. I worry about their skin and getting sore". At the time of the inspection no one had a pressure sore but if this practice continued there was a potential for skin integrity to be compromised. One the second day of our inspection we fed this back to the manager who told us she would revisit the new routines and speak with staff. The operations director told us after the inspection that the routines had reverted to the previous arrangement.

Staffing rotas evidenced there were occasions where shifts were not covered sufficiently. Staff confirmed this did occur despite efforts made to cover shifts with permanent staff and agency workers. These circumstances further compromised safety. At times there was a high use of agency staff which affected continuity of care despite staff on duty doing all they could to ensure agency staff were supported. Two agency staff told us there wasn't always time for them to receive a handover, so they were not always aware of people's needs and were heavily dependent on the care staff they were partnered with. In the afternoon on the first day of our inspection staff had not received a handover immediately when they came on duty, this was not a regular occurrence. It was evident this shift had been particularly busy.

One agency worker had never worked in the home and they shared with us their thoughts on their first shift and what worried them. Comments included, "I was shocked to see there was only two of us on the ground floor. People's care and support should be reviewed. I was told I could support two people with personal care on my own but I did not feel safe. Their mobility was very unsteady and they couldn't stand for long when I was trying to wash and dress them. People have been left unattended in the communal areas and those with poor mobility are at risk. The staff have made me feel welcome and we have done our best. Staff haven't had a break because they don't want to leave me on my own".

All permanent staff were emotional when we spoke with them during our visits. It was evident they were

frustrated, exhausted and worried about the people they cared for and their colleagues. Comments included, "We are constantly robbing Peter to pay Paul, there are not enough of us", "We skip breaks when we are not working a long day so that staff are not left alone. However, when we work a 12 hour shift we need a break which means there is a lot of lone working. A lot of people require two care staff for their needs", "I worry when I go home because we haven't been able to do everything and I worry it won't get picked up by staff on the next shift" and "I try to make time to sit and talk with the people but very often we are too busy. It can be a little better for a few hours in the afternoon but from tea time onwards it's busy again". One relative told us, "Sometimes there is not enough staff around, particularly the cleaning staff, this is really worse at weekends. I see some of the staff going without breaks just to get the work done".

After our inspection we were contacted by two whistle blowers. They told us a staff member had performed a transfer with a person on their own when there should have been two staff. The staff member was on their own because a second staff member had gone for a break. We contacted the manager and requested that they reported this to the local authority safeguarding team and submit a notification to CQC. In addition, they were asked to follow the providers disciplinary proceedings to address the misconduct by the staff member. The operations director contacted us to let us know that an additional staff member was now on duty from 8am to 8pm to cover staff breaks and support people in the communal areas.

These were breaches of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was very rarely any domestic cover over the weekend and the staff were only able to do a basic surface clean. Supplies in bathrooms and toilets ran out quickly and they could not keep up with the demand to replenish stock, for example soap and handtowels. Domestic staff told us, "I can't remember the last time we deep cleaned people's rooms", "I feel totally demoralised I can't to my job properly", "I am ashamed of the cleanliness and take this personally, but I don't know what else we can do". One relative contacted us with their concerns about the hygiene in the home during a recent weekend visit. They found faeces on a bathroom door handle on the Saturday and when they came back it was still there on the Sunday.

We could not be satisfied that people were protected from the risks of cross infection. Parts of the home were dirty, there was no soap in the dispensers throughout the home and some facilities did not have disposable hand towels. The house keeper and domestic staff told us the home had not been deep cleaned for some time. Clinical waste bins were either not suitable (peddle operated) or broken, this included bins in bathrooms and toilets. There was not an allocated infection control lead. The audits were not robust enough and too generalised, they had not identified the concerns we raised at this inspection. We spoke with the head housekeeper (who had recently reduced her hours from 30 to eight per week) and two other domestic staff. The home had lost 66 hours per week for cleaning duties since the inspection of December 2017. Recruiting into these positions had been fruitless and the provider had failed to look at ways of resolving this in the short term, for example looking at an outside contractor. After the inspection the operations director contacted us to inform us they were hiring an outside cleaning contractor until they had successfully recruited.

We could not be satisfied that management of medicines was always effective and safe. The drug round on the first day of our inspection took over three hours in the morning. The nurse did inform us that those people who required time sensitive medicines were prioritised for example those people who required medicines for Parkinson's. There was one nurse on duty. Previously when we inspected senior care staff and the deputy were trained to administer medicines to people who did not require nursing care. At this inspection the deputy was on maternity leave and there were no seniors currently employed.

One person was receiving end of life care and the nurse on duty had to stop her medicines round several times to administer medicines to them and comfort/reassure the family. As much as staff tried not to, there were always occasions where the nurse was interrupted due to a concern or question. On the second day of our inspection the medicine round was completed in a suitable timely manner. The person who was receiving end of life care was now receiving medicines via a syringe driver (a device used to administer medicines over a continuous period). In addition, there were more permanent, experienced staff on duty rather than agency This had enabled the medicine round to run more smoothly.

During the inspection we were told that there was not suitable equipment to meet people's medicine requirements. Syringes and needles had been obtained from the GP practice and district nurses. One person's Vitamin B12 injection was a week late due to this. Although this person's health would not be compromised it was an act of omission none the less. One person was having injections subcutaneously (just under the skin) and the medicine they needed required a special syringe and needle. We were told these had been supplied by the district nurses. On the second day of our inspection we fed this back to the manager who told us she would order supplies. After the inspection we were contacted by the operations director who informed us there were plenty of these supplies in the home. Collectively the manager and two nurses had worked at the home between three to eight months and none of them were aware of this stock and where it was kept.

The homes syringe driver had not had necessary checks to make sure it was fit for purpose and again the home was reliant on resources from the district nurses.

These were breaches of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the concerns we identified people did tell us they felt safe with staff and that they were kind and caring. Comments included, "Yes I feel safe around here, they check on me all of the time, even at night when I am in bed they come into my room to see if I am alright", "I like to stay in my room a lot, I like peace and quiet, they still come and see me to make sure I am okay, I see them walking past the door", and "I am safe in here, I do like to go outside to smoke, but I am not safe by myself, so the staff take me out when they can".

Staff were knowledgeable on how to manage risks relating to people's health and well-being and how to respond to these. This included risks associated with weight loss, maintaining skin integrity and difficulty with swallowing and potential choking risks. People's records provided staff with information about these risks and the action staff should take to reduce these. These records had improved over recent months following ongoing review and evaluation of the clinical lead.

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. The manager considered any trends to help ensure further reoccurrences were prevented.

Staff files evidenced that safe recruitment procedures were followed. 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 had any past convictions that may prevent them from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective and required improvement. Although there had been improvements made to the environment and plans to improve were ongoing, some people's rooms had not been given priority. Rooms on the ground floor were particularly offensive, they smelt unpleasant and this permeated into the corridors. Carpets were in poor repair, stained and beyond deep cleaning. These rooms had been referred to in previous inspection reports and yet had still not been addressed. The manager told us about a programme to decorate these rooms and how it would be managed with consent and agreement from people and where required their family. We saw several empty 'showrooms' that had been refurbished which could be used to help facilitate the upgrades of the rooms that were particularly poor.

This was a breach of Regulation 15 Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt that induction training was not always satisfactory. Comments included, "It was a bit hit and miss because staff were busy", "My induction didn't really happen" and "It wasn't the induction that was planned but I could contact staff within the organisation if I had any questions". We were assured by the previous covering manager at the last inspection that a robust induction would take place. This was to help ensure the improvements that had been made would be sustained and further improvements identified in the action plan would be met. Due to unforeseen circumstances this did not occur. There had also been several changes in area manager which had also compromised the managers induction and the oversight and continuity of the running of the service. The fact that neither the manager or nurses knew where stock of needles and syringes were demonstrated that induction needed to improve.

This was a breach of 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had continued to ensure staff received training updates since the inspection of December 2017. Collectively they had the skills and confidence to carry out their roles and responsibilities effectively. One staff member we spoke with explained the training they received and said there was 'plenty and it had been useful'. They went onto to explain that the face to face practical training was 'well delivered and enjoyable'. Staff told us they received supervisions and they were useful. Despite frustrations staff were complimentary about the way they worked as a team and they considered their colleagues as 'kind and caring' people. One newly appointed staff member had previously worked as an agency carer at the home. They enjoyed working at the home and told us staff had been 'supportive and worked very hard'.

Staff had received training on the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The manager was enrolled to attend advanced training provided by South Gloucestershire local authority. The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions. 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 with appropriate legal authority. 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 authorisation's to deprive a person of their liberty had the appropriate legal authority and were being met. Staff understood the principles of the MCA and, how to implement this for those people who did not have mental capacity and, how to support best interest decision making. This included those decisions that would require a discussion with family, and possibly other significant people, for example health and social care professionals.

People continued to receive a healthy nutritious diet. Choice of meals and mealtimes were flexible each day dependent on personal preferences and daily routines. New menus had been recently devised with people. We asked people their thoughts on the food. Comments included, "The food is very good here I always get enough to eat, I eat it all and I am never hungry here", "The food is okay, you get enough to eat and drink I never get thirsty", "I have chosen my lunch, I am having Scampi today, I choose all my food it's always good". One relative told us, "The food here is very good, I am staying here a lot now to be with my mum. They are providing me with meals, you get a really good choice". In the lounge area there was a table with a selection of fruit juices, a bowl of fruit and snacks for people to help themselves. We saw staff offering drinks and snacks throughout the day.

The reception had been decorated and a reception desk had been installed. There was a receptionist to greet all visitors, from Monday to Friday. There were hot beverages for people to help themselves and lots of literature and useful leaflets to keep them up to date. The outside of the house had improved and looked well kept, much more inviting and cared for. One communal lounge and dining areas had been refurbished and new furniture had been ordered.

Requires Improvement

Is the service caring?

Our findings

The home did not always provide a caring service. Without doubt, staff we met were very caring, kind and had good intentions to provide compassionate care. However, improvements were required and this was predominantly because of the other failings in the home, for example poor staffing levels. To instruct their staff on occasions to just 'wash hands, face and bottoms' was not caring. It did not reflect person centred care and showed a total lack of dignity and respect.

Every member of staff we spoke with said they would not recommend the home to a loved one at this present time. Staff told us the little things that mattered for example taking the time to talk with people, play a game or to offer a pamper session. However, they told us this didn't happen as much as it used to due to time constraints. We saw several ladies with long, dirty finger nails and some people looked unkempt.

The cleanliness of the home and parts of the environment did not support a service that promoted dignity and respect. For example, stained carpets in bedrooms, curtains were missing hooks so they were not hung properly and the quality of the bedding was poor and thin. When we looked under and behind beds we found used tissues, sweet wrappers and discarded lids to toiletries.

This was a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they felt that the staff were caring. Comments included, "The staff are all very nice towards me, they know how I like things done and they do it just right", "I am happy here, they treat me so well", "The girls are wonderful people, they look after us all so well, they really know how to care" and "The staff are all very nice, never a bad word, they always call you by name". One relative told us, "The staff are all wonderful towards me and my mum, just like a really big happy family". They explained their loved one was receiving end of life care and the staff had been lovely and supportive. They went on to say, "I think my mum is well loved by all of the staff here, they show genuine emotion which shows their quality as carers".

Requires Improvement

Is the service responsive?

Our findings

A responsive service was not always provided and improvements were required. Person centred care was compromised. People were not always receiving care that met their needs and personal preferences, this particularly related to personal care, continence needs and getting up and going to bed at preferred times. Evidence of this is demonstrated under safe and caring in this report. In addition, staff confirmed that care was becoming 'task orientated, care was being rushed, they were having to cut corners and baths and showers rarely occurred'.

We met with the clinical lead who had been looking at care documentation to improve the quality of the information. We read some care plans that had really improved and provided a good level of detail about how people wanted and needed to be supported. The ability of staff being able to promote and support personal preferences could be compromised given the improvements required around staffing levels and routines. Risk assessments had also improved. Further improvements were required but it was important that the quality was not compromised by rushing them and full participation of people and their families must continue.

It was noted that the clinical lead only had 9 hours per week supernumerary to complete this and to perform other duties as a clinical lead would be difficult. They had several new ideas to make the service a more effective, responsive service. This included, MOT clinics to invite people to health checks and looking at evolving champion and lead roles for staff who want to become experts. In light of improvements required around dignity and respect, medicine management, infection control and person-centred care it's imperative these roles are considered in the future.

Activities were not satisfactory nor were they person centred. At the inspection of 2016 and 2017 we had made recommendations for the provider to review this. We spoke to people regarding the quality and quantity of the current activities within the home. Comments included, "I do get bored here sometimes with nothing to do", "Sometimes I will have a nice chat with staff when they have some time in the afternoon", "There isn't much going on but I like my room and my own company", "I am bored today there is nothing to do just that thing on (pointing at the television)", "Just sitting here is boring I cannot hear the television and I cannot read the writing on the screen (The subtitles were on the television)".

There was a part time activity coordinator, but we were told they covered kitchen assistant vacancies more often than providing any activity. Staff explained that care delivered was an activity and provided the opportunity of company and conversation. However, staff numbers and routines meant this wasn't the case anymore. Although some entertainment/visitors were booked during the month this did not meet everyone's personal choice. On the afternoon of day one of our inspection someone came into the home and led a chair exercise class for a small group of people. There were no staff members present during this activity because they were attending to other people. We were informed by a staff member the attendance would be recorded in the care plan later by the care staff. As they were not present during the activity it would be difficult to complete the care record and know whether it was meaningful to the individual. The manager told us they had sorted through activity resources in the home and thrown away things that were

not suitable, broken or had pieces missing. No further progress had been made.

These were breaches of Regulation 9 Person centred care of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager followed the homes policy and procedure to address formal complaints and clear records were kept of the outcomes and actions taken. A person living in the home told us, "I made a complaint to the manager and she dealt with this and I was very satisfied". One relative told us, "I have had no cause to complain about anything. The communication between the home and myself is very good, you can speak to the nurse or the manager at any time and they always listen to you".

Requires Improvement

Is the service well-led?

Our findings

The breaches throughout this report demonstrated the service was not always well led and improvements were required. It was difficult to determine as to why the service had deteriorated since the inspection of December 2017 where they received a rating of Good. Collectively changes in the management structure, the absence of the deputy, senior care staff and staff vacancies had attributed to an ineffective, inconsistent management of the service. For example, the service had lost 66 hours in domestic cleaning and this would explain the poor cleanliness of the home and the infection control risks we found.

The audits and provider oversight was not always effective. This meant that they had not identified that the service required improvements in some areas, for example the infection control audit. This audit was vague and spot checks were not being completed throughout the home.

Although staff views were positive about the manager, we could not be satisfied the manager was supported by the provider to effect change and was equipped with the skills to make decisions autonomously. Since her appointment she would benefit from more support/guidance and further ongoing induction. Staff were frustrated that concerns were not always addressed, they felt this could be because the manager was not supported by her line managers to make effective change. One staff member we spoke with said, "The manager is very supportive towards the staff, but is not always supported themselves by other members of the team or maybe her own management structure". Two visiting health care professionals told us they thought the manager was enthusiastic and their intentions were to provide a good service to people. After the inspection the operations director had made several visits to the home to help support the manager and made some immediate changes we have referred to in the report. In addition, two area managers had been spending time at the home following the feedback after the inspection. One of which would oversee the whole home and base themselves at the service five days a week.

These were breaches in Regulation 17 Good governance of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of understanding from the manager about when they should notify CQC of certain events. Again, this was something that should have been covered in their induction. These notifications inform CQC of events happening in the service and are a legal requirement. Improvements were required with regards to the quality and the written content. We use this information to monitor the service and ensure they respond appropriately to keep people safe and meet their responsibilities as a service provider.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

During the inspection people told us they saw the manager on a regular basis. Comments included, "The manager is very good, she comes around and talks to you all of the time", "The manager comes around and speaks to you every day", "I have no complaints here at all, I see the manager everyday checking up to make sure I am alright" and "I see the manager around the home and we have meetings you can talk to them anytime, they make time to listen to you". One relative told us, "The manager is always available to speak to

you, a very nice person who will always listen to your point of view, they lead the team well. I would not hesitate to recommend this home to anyone".

Some of the audits we looked at demonstrated improvements within the service and that action was taken when shortfalls were identified. Care plan audits were a good example where the quality of information had improved, and consistency of review and evaluation of people's needs and risk assessments were achieving higher pass rate scores. Written feedback was provided to the nurses with regards to things that required additions and this was followed up by the manager to ensure it had been completed.

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 18 Registration Regulations 2009 Notifications of other incidents The service had not always notified us of events as required by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care. Activities required improvement so that they were person centred and meaningful.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and respect was not always promoted or supported.

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 We could not be satisfied that management of medicines were safe. The home's policy and procedures for cross infection did not protect people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Parts of the home were in poor repair and required refurbishment and decoration.

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 Effective quality monitoring systems were not in place. Systems did not drive improvement in the quality and safety in some of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We could not be satisfied that staffing levels protected people and kept them safe. Induction for new staff was not satisfactory.