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Boscobel

Inspection report

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Date of inspection visit:
09 February 2018
13 February 2018

Date of publication:
19 March 2018

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Requires Improvement 

Is the service effective?

Inadequate 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This unannounced inspection was conducted on 9 and 13 February 2018.

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

Boscobel provides accommodation and personal care for up to 20 people with learning disabilities. It is a large Victorian property with accommodation located over three floors. A ramp and steps provide access to the front of the building. The upper floors are accessed via staircases. There is a dining area to the ground floor and a lounge. A garden area is located at the rear of the building and parking at the front. At the time of the inspection 13 people were living at the service.

A registered manager was in post. The registered manager was not available on either day of the inspection. 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.

Following the last inspection in May 2017 the provider submitted an application to cancel the registration at Boscobel. At the time of this inspection the application was under consideration by the Commission.

At the last inspection in May 2017 we identified breaches of the regulations in relation to; person-centred care, dignity and respect, safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, good governance, staffing, fit and proper persons employed, requirements as to display of performance assessments and notification of other incidents.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when. As part of this inspection, we checked whether the actions identified in the provider's action plan had been completed.

There was no evidence that risks had been reviewed in accordance with the provider's action plan. The failure to review risk meant that the service could not be certain that people were protected from avoidable harm.

Recruitment practices had not been improved as required.

Applications to deprive these people of their liberty had not been submitted in accordance with the Mental Capacity Act 2005. This meant that people were at risk of being unlawfully detained.

There was no record to indicate that their competency had been checked in accordance with the principles of the Care Certificate. This meant that the service could not be certain that they met the required minimum standards and were able to deliver safe, effective care.

We found that health action plans were not consistently completed and one person's record showed no evidence that a serious health condition had been reviewed.

None of the six plans we checked had been recently reviewed. This meant that the provider could not be sure that people's care needs were accurately reflected in the records.

We looked care records and saw evidence that person-centred plans had been developed for some people. Where they had been fully completed they contained detailed information for staff about people's histories, likes, dislikes and goals. However, of the six care records we saw, only four had a completed person-centred plan.

At the last inspection we identified that safety and quality audits had not been effective in identifying issues and driving remedial action. The records that we saw indicated that some progress had been made and that audits were now more extensive. However, there was no structured audit or oversight at provider level.

Improvements had been made to medicines' management and medicines were safely managed in accordance with best-practice guidance.

At the last inspection the general level of cleanliness in the home was poor. As part of this inspection we checked to see if the necessary improvements had been made and sustained and found that they had been.

Staffing numbers were adequate to meet the needs of people living at the service. A minimum of three care staff were deployed on each daytime shift. This reduced to two waking staff overnight. Additional staff included a cook, a domestic and an administrator.

People spoke positively about the provision of food and drinks and were given a choice of meals.

We spoke with two visiting healthcare professionals about the quality of communication and support provided at Boscobel. Each person spoke positively about the timeliness of communication from staff and the effectiveness of staff support in following treatment plans. We were given examples where people's health and wellbeing had improved following good partnership working with healthcare services. For example, one person had regained their mobility following a course of treatment.

Staff told us that they received regular training and supervision and felt supported by the registered manager and senior staff. We saw from records that the majority of staff had been given formal supervision since the last inspection.

People spoke positively about the staff and their approach to the provision of care. It was clear from our observations that staff knew people well and were able to respond to their needs in a timely manner.

People had access to a range of activities within their own homes and communities. Staff provided additional support as required. Activities included; watching television, movie nights, singers and crafts.

People's rooms were personalised with personal items and family photographs. The rooms that we saw were decorated in different styles and colours and furnished to a basic standard.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Individual risks had not been assessed to mitigate risks to people's health, safety and welfare.

Improvements to practice had not been made to ensure that staff were safely recruited.

Medicines were safely stored and administered by trained staff.

Requires Improvement ●

Is the service effective?

The service was not effective.

Applications to deprive people of their liberty had not been completed and submitted as required.

New staff had not had their competency to do their job formally assessed in-line with good practice.

People were supported to access a range of healthcare services in accordance with their needs.

Inadequate ●

Is the service caring?

The service was not always caring.

People's right to privacy and dignity was not always protected.

People told us that the staff were caring and we saw that they spoke and acted with kindness and compassion during the inspection.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Care plans had not been reviewed to ensure they reflected people's changing needs.

Not all care records contained sufficient person-centred

Requires Improvement ●

information for staff to know people's likes and dislikes.

People understood the complaints procedure. There had been no formal complaints submitted since the last inspection.

Is the service well-led?

The service was not well-led.

The provider had not completed the action plan they had submitted to the Commission at the last inspection in order to improve the quality and safety of the service.

There was no structured oversight of the service by the provider.

Audit processes had failed to identify issues and drive improvement in accordance with agreed timescales.

Inadequate ●

Boscobel

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 inspection took place over two days on 9 and 15 February. The first day of the inspection was unannounced.

The inspection was conducted by two adult social care inspectors.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We contacted professionals connected with the service and asked for their views. We used all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with five people living at the home, a family member, four staff and one of the owners. We also spoke with two visiting healthcare professionals. The registered manager was not available on either of the inspections days. We spent time looking at records, including six care records, four staff files, medication administration record (MAR) sheets and other records relating to the management of the service.

Is the service safe?

Our findings

At the last inspection in May 2017 we identified breaches of regulation 12 in relation to safe care and treatment. We received an action plan from the provider which detailed how the necessary improvements would be made and by what date. As part of this inspection we checked to see if the necessary improvements had been made and sustained.

At the last inspection we saw evidence in care records that people's risks were not fully assessed or regularly reviewed. The provider's action plan indicated that a full review of risk would be completed by 7 July 2017 in order to improve risk management. During this inspection we checked care records for evidence that risk had been reviewed as required. There was no evidence that people's risks had been reviewed in accordance with the provider's action plan. This failure to review risk meant that the service could not be certain that people were protected from avoidable harm. We spoke with staff and the provider about this and were told that the work may have been completed, but no evidence could be found. The registered manager was not available on either day of the inspection to confirm if risk had been reviewed as required.

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

During inspection, we were given further assurances by the provider that risk assessments would be reviewed as a priority.

At the last inspection we found that some staff had not been safely recruited. The provider's action plan stated that recruitment processes would be improved by 16 June 2017. As part of this inspection we checked four staff records to see if the necessary improvements had been made. We saw no evidence that criminal conviction checks for long-standing staff had been reviewed as required. This meant that the service could not be certain if their staff remained suitable to work with vulnerable adults. At the last inspection we saw that references for some staff could not be easily verified. During this inspection we saw that the references obtained for one recent employee did not contain any details regarding their source. They were signed, but did not provide a name of the organisation or the referee. This meant that these references could not be easily verified in line with safe recruitment practice.

This meant there was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified that safety checks and practice relating to; hot water temperatures, legionella, and fire were not sufficiently robust to protect people from the risk of harm. This meant that at the last inspection, the provider was in breach of Regulation 12 with regards to the premises and equipment. At this inspection, we checked records relating to the premises and the environment and found that improvements had been made in accordance with the provider's action plan. Hot water temperatures were regularly checked to ensure that the risk of legionella was reduced. Work to install thermostatic control valves on hot water outlets had not been completed. However, since the last inspection, the risks associated

with people being exposed to excessive water temperatures that posed a scalding risk had been assessed and managed. Checks on essential fire safety equipment had been completed in accordance with good practice. This meant the provider was no longer in breach of regulation 12 regarding premises and equipment.

At the last inspection we saw that practice in relation to the storage and administration of controlled drugs was not robust. This meant there was a breach of Regulation 12 with regards to medication management. Controlled drugs are medicines with additional controls in place because of their potential for misuse. As part of this inspection we planned to evaluate practice in relation to controlled drugs. However, we were informed that none of the people living at Boscobel at the time of the inspection required a controlled drug. This meant we were unable to check the management of controlled medication as this inspection. We looked at records relating to the management of other medications in use at the home and saw that they had been completed correctly. There was clear evidence that stocks of all medicines were checked twice each day as part of the staff handover. People had PRN (as required) protocols in place to provide staff with guidance on how and when to administer these medications. Creams and other topical medicines were stored and administered safely. We spot-checked Medicine Administration Record (MAR) sheets and stock levels for five people's medicines. Stock levels for these medicines were accurate and the MAR sheets had been completed correctly. The temperature of the area where medicines were stored and the refrigerator were checked on a regular basis and remained within safe limits. This meant the provider was no longer in breach of regulation 12 regarding the safe administration of medicines.

At the last inspection the provider was in breach of regulation 15 with regards to premises and equipment because the general level of cleanliness was poor. At this inspection, we saw that Boscobel was generally clean and free from odours. The bathroom which was of concern at the last inspection was stocked with hand towels and toilet tissue, but there was still evidence of mould on the ceiling. We raised this with a member of staff and immediate action was taken. We found that the required improvements with regards to the cleanliness of the environment in which people lived had been made. This meant the provider was no longer in breach of regulation 15 in relation to premises and equipment.

People told us that they felt safe living at Boscobel. Comments included; "We all feel safe", "Having staff around makes me feel safe" and "I always get my tablets on time." One relative commented, "It's cleaner now and from a safety aspect it's better."

Staff had completed training in adult safeguarding procedures and were able to explain what action they would take if they suspected abuse or neglect. One member of staff explained in detail what signs they would look for to show that a person was anxious or distressed. This level of understanding helped to keep people safe. Each staff member said that they would not hesitate to whistleblow (report to an independent body) any concerns they had if necessary. There had been no safeguarding referrals since the last inspection.

Staffing numbers were adequate to meet the needs of people living at the service. A minimum of three care staff were deployed on each daytime shift. This reduced to two waking staff overnight. Additional staff included a cook, a domestic and an administrator.

Accidents and incidents were accurately recorded, sufficiently detailed and included reference to actions taken following accidents and incidents. Six accidents had been recorded since the last inspection. There was evidence that lessons had been learned following accidents. For example, due to the action taken with regards to one person's vulnerability to falls at the rear of the building, the risk of the person falling had been reduced resulting in no recent incidents of a fall being recorded and staff confirmed that they were not

aware of any.

Is the service effective?

Our findings

At the last inspection we identified a breach of regulation 11 with regard to the need for people to consent to their care and treatment because applications to deprive people of their liberty had not been submitted as required. The provider indicated that they would ensure compliance with this regulation by 23 June 2017. As part of this inspection we checked to see if appropriate action had been taken. We found it had not.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw evidence that consent had been sought and recorded in accordance with the requirements of the MCA. We also saw that staff explained what they were doing and asked for consent before providing care. The records that we saw indicated that two applications to deprive people of their liberty had been submitted. Care records and discussions with staff however indicated that a further three people were being deprived of their liberty in their best-interests because they may not be safe to access the community on their own. Applications to deprive these people of their liberty had not been submitted. This meant that people were still being placed at risk of being unlawfully detained.

This meant there was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last two inspections of the service in November 2016 and May 2017 we had concerns about the quality and structure of induction training for new staff. In particular we were concerned that the records of induction were not sufficiently robust to demonstrate compliance with the principles of the Care Certificate. The Care Certificate requires new staff to complete a programme of training, be observed in practice and then signed-off as competent by a senior colleague within 12 weeks of their employment. Following both previous inspections, the provider assured the Commission that appropriate action would be taken to ensure that the induction of new staff members was complied with the requirements of the Care Certificate by 30 June 2017. At this inspection, when we checked the staff files and training records of two recently appointed staff we found that there was no evidence to show that the provider's induction process for new staff included an assessment of their competency. This meant that the service could not be certain that the staff members concerned met the required minimum standards of competency to enable them to deliver safe, effective care.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

At the last inspection we identified a breach of regulation 17 because records relating to people's healthcare needs were not sufficient to ensure that people received safe, effective care and sometimes contained confusing information. As part of this inspection we checked to see if the necessary improvements had been made and sustained. We found that the majority of the records were sufficiently detailed, but we saw that information regarding healthcare was disjointed and difficult to track. Health action plans were not consistently completed and one person's record showed no evidence that a serious health condition had been reviewed. Another record stated that the person had a health condition that required them to use a wheelchair, but also contained a statement that the person walked unaided. This failure to maintain complete and accurate records relating to healthcare placed people at risk of receiving unsafe or inappropriate care.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the inspection process we checked the dining room and sampled a meal. We also spoke to people about the food and drinks available. The food was well-presented and nutritionally balanced. People told us that they enjoyed the food and were given a good choice. One person said, "The food is alright. It's good. We've had pancakes. I had had cheese and beetroot for my lunch." While another commented, "I like the mince pies." The menu was not displayed in the dining room, but people were asked each day about their preference by a member of staff. Each of the people that we spoke with confirmed that they could ask for an alternative. People told us that they were offered plenty of drinks throughout the day.

We spoke with two visiting healthcare professionals about the quality of communication and support provided at Boscobel. Each person spoke positively about the timeliness of communication from staff and the effectiveness of staff support in following treatment plans. We were given examples where people's health and wellbeing had improved following good partnership working with healthcare services. For example, one person had regained their mobility following a course of treatment.

We saw from training records that staff had recently completed training which was relevant to their roles. Training included; MCA, DoLS, fire safety and equality and diversity. Staff also told us that they had been given access to training to develop their skills and competencies. For example, one member of staff was close to completing an accredited qualification at level three.

The staff that we spoke with had a basic understanding of current legislation and standards. However, none of the records or audits that we saw made reference to legislation or best-practice guidance. This meant that opportunities to demonstrate compliance and generate improvements in safety and quality were not maximised. We also asked staff about people's needs in relation to equality and diversity. We were given examples of how staff supported people with needs relating to their disability and faith.

Staff told us that they received regular supervision and felt well supported by the registered manager and senior staff. We saw from records that the majority of staff had been given formal supervision since the last inspection.

Is the service caring?

Our findings

At the last inspection identified a breach of regulation because care plans had not been reviewed to ensure that people were involved in decisions about their care, people's right to vote had not been recognised and people's right to privacy was compromised. As part of this inspection we checked to see if the necessary improvements had been made and sustained.

Each of the six care records we looked at contained care plans to instruct staff. However, none of the plans had been recently reviewed. This meant that the provider could not be sure that people's care needs were accurately reflected in the records.

We also checked the toilet in the basement which did not have a lock on the door at our last inspection to ensure people's right to privacy was respected. We saw that no action to address this had been taken. This meant that people's right to privacy could still be compromised as there was a risk that other people could access the toilet when it was in use.

People spoke positively about the staff and their approach to the provision of care. Comments from people living at the home included; "Staff are nice" and "Staff do a lot for people." A visiting relative told us, "It's like a home. They [people living at Boscobel and staff] are like one big family. There's an attachment there."

It was clear from our observations that staff knew people well and were able to respond to their needs in a timely manner. Staff were able to tell us about people's individual traits and preferences. For example, staff explained what the typical week looked like for people without referring to records. Interactions were warm and friendly and it was clear that people living at Boscobel were relaxed in the company of staff. We saw examples of staff discussing options and alternatives with people and respecting their wishes. For example, in relation to food choices.

People living at Boscobel were encouraged and supported to be as independent as possible. The service included three semi-independent units which offered people greater independence and the opportunity to develop new skills. Other people were encouraged to access the community independently to go shopping, access social activities, or volunteer.

People living at the home had access to their own room with washing facilities for the provision of personal care if required. The home also had shared bathing and showering facilities. When we spoke with staff they demonstrated that they understood people's right to privacy and the need to maintain dignity and choice in the provision of care.

We spoke with a relative during the inspection. They told us that they were free to visit at any time. People living at the home confirmed that this was the case. Relatives made use of the communal areas, but could also access people's bedrooms for greater privacy.

The home displayed information about independent advocacy services. We were told that none of the

people currently living at the service were using advocacy services. We saw from care records that people were able to advocate for themselves or had nominated a family member to act on their behalf.

Is the service responsive?

Our findings

Following the last inspection in May 2017 the provider submitted an application to cancel the registration at Boscobel. At the time of this inspection the application was under consideration by the Commission.

At the last inspection in May 2017 we identified a breach of regulation 17 because care records did not contain sufficient person-centred information. This meant that the service could not be certain that plans were safe or effective in directing staff or respecting people's wishes. During this inspection we checked to see if improvements had been made to ensure people's care records reflected their needs and wishes. We found that the information in some people's care files had improved but others had not.

We looked care records and saw evidence that person-centred plans had been developed for some people. Where they had been fully completed they contained detailed information for staff about people's histories, likes, dislikes and goals. However, of the six care records we saw, only four had a completed person-centred plan. We also saw that people's care plans had not been reviewed in accordance with the provider's action plan. Some of the plans had not been reviewed for a number of years. This meant that the provider could not be certain that the care plans accurately reflected people's care needs and instructed staff appropriately.

This is was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a range of activities within their own homes and communities. Staff provided additional support as required. Activities included; watching television, movie nights, singers and crafts. For example, we saw a small group of people being supported to make Valentine's day cards. People told us that they had enough activities to participate in to meet their needs. One person commented, "I do card-making, watch telly, go to meetings. We have days out." They also told us that they knew how to complain and were confident that staff would listen and act. They said, "[If I needed to complain] I'd tell staff. They'd do something about it."

People's rooms were personalised with personal items and family photographs. The rooms that we saw were decorated in different styles and colours and furnished to a basic standard. At the last inspection we saw that one room had a noticeable malodour which spread to the hallway and other shared areas during the inspection. As part of this inspection we checked to see if the situation had improved. There was no noticeable odour in or near the person's room on either day of the inspection. A member of staff was able to explain how the issue had been resolved.

We observed that care was not provided routinely or according to a strict timetable. For example, people were able to get up and go to bed at different times or change their minds about mealtimes. Staff were able to respond to people's needs and provided care as it was required. We asked people living at the home if they had a choice about who provided their care. None of the people that we spoke with expressed concern about their choice of carers.

Information regarding compliments and complaints was displayed in the main hallway. The people that we spoke with said that they knew what to do if they wanted to make a complaint. Staff told us that there had been no formal complaints made since the last inspection.

The service considered people's wishes for end of life care. One record contained extensive and detailed information about a person's wishes including; flowers and hymn choices.

Is the service well-led?

Our findings

A registered manager was in post, but was not available on either day of the inspection because of ill-health. The registered manager was appointed in November 2016 and was supported in the day to day management of the service by senior carers and an administrator.

Following our inspections in November 2016 and May 2017 the service was found to be in breach of regulation 17 with regard to good governance. After both of these inspections, the provider submitted an action plan to The Commission detailing the actions they intended to undertake to address the issues arising out of the inspections so that compliance with regulation 17 was achieved. At this inspection we checked to see if the necessary progress had been made and sustained. We found it had not.

The action plan produced following the inspection in May 2017 had not been completed as required. This was also the case with regard to the action plan submitted by the provider after the in November 2016.

At the last inspection we identified that the safety and quality audits undertaken by the provider were not effective in identifying and mitigating risks to people's health, safety and welfare. This meant that remedial action was not always taken. As part of this inspection we saw that some progress had been made with regards to improving the audit processes in place. The audits were now more extensive, but were not effective in driving improvement. For example, in relation to the provider's action plan. There was no evidence of any audit or oversight at provider level. This meant that the safety and quality of the home was not monitored as required.

This is was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In November 2016 and May 2017 we saw that the service was not displaying its current inspection rating as required. We noted at this inspection, this had been rectified and the current ratings were now displayed appropriately. This meant the provider was no longer in breach of regulation 20(A) in relation to this requirement.

During the previous inspection notifications about significant events had not been submitted to the Commission by the provider as legally required. At this inspection records indicated that no reportable incidents had occurred in the period so we were unable to assess whether improvements had been made in this area.

The service had a set of policies and procedures which provided detailed and specific guidance. The staff that we spoke with were familiar with the policies and how to access them.

People living at the service and staff were consulted about the service through resident and relative meetings and staff meetings. We saw evidence that information about events and developments was provided at these meetings and people's views were sought. For example, people were consulted about

potential changes in the management of the service.

Staff said that they understood what was expected of them and were motivated to provide good quality care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Applications to deprive people of their liberty had not been submitted as required.
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Individual risk had not been assessed or reviewed.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were incomplete, had not been reviewed and contained conflicting information. The provider's action plan had not been completed following the last inspection. Audits were not effective in identifying concerns. There was no structured oversight of the service by the provider.
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Some staff references had not been verified. DBS checks had not been reviewed as required.
Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

New staff had not had their competency assessed before working independently.