The Keepings Limited

# Birkdale Residential Home

## Inspection report

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Date of inspection visit:
23 November 2017

Date of publication:
08 January 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This unannounced inspection took place on 23 November 2017. At our previous inspection in August 2016 we found that service was not always responsive or well led and the provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspections we found that minor improvements had been made in one area, however we found further concerns as the service was not consistently safe, effective, caring, responsive or well led. We found six breaches of Regulations. The overall rating for this service is Inadequate which means it will be in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Birkdale Residential Home provides accommodation and personal care for up to 27 people. At the time of the inspection 25 people were using the service including some people who were living with dementia.

We were supported throughout the inspection by the registered manager. 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.

Risks of harm to people were not being assessed, managed or reduced to prevent further incidents which had resulted in harm. Lessons were not being learned to ensure incidents and accidents were minimised.

People were not protected from the spread of infection as prevention measures were not being followed effectively.

People's medicines were not always administered safely.

There were sufficient numbers of staff however they were not always deployed safely. New staff had been employed through safe recruitment procedures.

People's needs were not assessed holistically to achieve effective outcomes. People were not cared for by staff who were trained and supported to fulfil their roles effectively.

People's nutritional needs were not always met and when people became unwell or their health care needs changed the appropriate health care advice was not always sought in a timely manner.

The principles of the Mental Capacity Act 2005 (MCA) were not always followed to ensure that people who lacked the mental capacity to agree to their care and support were supported to do so in their best interests.

The building and environment required further adaption to meet the needs of people who used the service.

People were not always treated with dignity and respect and people's choices and preferences were not always respected.

People's needs were not assessed effectively and their preferences were not always gained.

Complaints and concerns were not dealt with appropriately and some people did not feel their complaints were taken seriously.

The governance systems the provider had in place to monitor and improve the service were not effective in ensuring improvements were made.

People were safeguarded from the risk of abuse as the staff and management knew what to do if they suspected abuse.

There were a range of hobbies and activities to support people to maintain active and promote their well being.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not consistently safe.

Risks of harm to people were not always minimised and lessons were not always learned following accidents and incidents.

People's medicines were not always managed safely.

Safe Infection control prevention measures were not being followed.

The equipment in use with people was not always safe and requirements in relation to fire safety were not always followed.

There were sufficient numbers of staff however they were not always deployed effectively.

People were safeguarded from the risk of abuse as the local safeguarding procedures were being followed.

### Is the service effective?

**Inadequate**

The service was not effective.

People who used the service did not receive a holistic service and were not always supported by staff who were trained and effective in their roles.

People's needs were not assessed and when their needs changed or they became unwell the appropriate health care support was not gained in a timely manner.

Staff did not follow national guidance in delivering care that met people's needs in an effective way. The provider was not following the principles of the MCA and ensuring that when people lacked the mental capacity to agree to their care they were supported to do so in their best interests.

The building and environment was not adapted to meet people's individual needs and preferences.

## Is the service caring?

Inadequate

The service was not consistently caring.

People were not always treated with dignity and respect.

People's choices were not always respected and they were not always listened to.

People's right to privacy was not always upheld.

## Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's personal preferences were not always gained and respected.

Complaints and concerns were not responded to according to the provider's complaints procedure.

There was a range of hobbies and activities available to people.

## Is the service well-led?

Inadequate

The service was not well led.

The governance systems the provider had in place had not been effective in improving the quality of care.

People and their relatives were asked their view on the care they received however action was not taken to improve the care when concerns were raised.

Staff did not always work with other agencies to ensure that a holistic approach was taken to people's care.

Analysis of accidents and incidents were not effective as lessons were not learned and the quality of care was not improved.

# Birkdale Residential Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 on 23 November 2017 and was unannounced. It was undertaken by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 10 people who used the service and 3 visiting relatives. We spoke with two care staff, the cook, the registered manager and deputy manager.

We looked at four people's care records and three staff recruitment files. We checked the maintenance records, looked at rotas and the medication system. We looked at the systems the provider had in place to monitor and improve the quality of the service.

Inadequate

# Is the service safe?

## Our findings

At our previous inspection we had no concerns in the safety of the service. At this inspection we found that risks were not always minimised and lessons not always learned following incidents and accidents that resulted in harm. We found that people's medicines were not always administered safely and that infection control procedures were not always followed. We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that one person had recently fallen at night and received a head injury. We looked at the accident records and saw that they had fallen several times over a eight month period and received several minor injuries. Most of these falls had occurred at night time. We looked at the person's risk assessment and saw that although it had been reviewed monthly, no changes had been recorded and although a brighter light had been installed in their ensuite no other action had been taken to minimise the risk of this person falling at night time. This meant that risks of harm to this person were not being reduced and lessons were not being learned following accidents and incidents.

One person was prescribed 'as required' medication for when they were agitated. These medications are known as antipsychotic medication. We saw that the person was being regularly administered the medication, however there was no justification as to why the person was being given it as records did not show that the person had been agitated. The person was also prescribed pain relief and we saw they were complaining of pain on the day of the inspection. Yet the antipsychotic medication had been administered without a definitive time gap for the pain relief to take effect. There were no written instructions as to when the medication should be given and the person was unable to communicate so staff were able to understand. It was unclear whether the person was actually in pain or experiencing agitation. This meant that this person was at risk of having medication they did not require.

We looked at the infection control measures throughout the service and found that there were areas that required improvement. We saw that the cook was not wearing protective clothing when cooking in the kitchen. We saw they left the kitchen regularly to walk through the lounge, go into the garden and transfer some people into the community by car and they did not cover their own clothing. This would mean that the cook was at risk of transferring bacteria from their own clothes whilst cooking. We saw some areas of the service were not cleaned thoroughly. We saw that several people had dropped bits of food from their breakfast on the dining room floor and these remained there all day. One person was incontinent of urine on a soft material lounge chair and staff supported them to change. However staff did not attempt to clean the chair or put something on it to prevent anyone else from sitting on it. We found that a mattress audit had identified that 11 mattress were worn and some were soiled and needed replacing. However the registered manager had yet to ask the provider to replace the mattresses, three weeks after they had been found in a soiled condition. This meant that the risk of infection was not being reduced through safe infection control measures.

We found that the 'sluice' door was left open and unlocked. There was a bold sign on the front of the door informing staff to keep the door locked but we found it unlocked throughout the day. This put people at risk

as the sluice facility had hot water and items in it that would put people at risk of infection.

We found that the required fire tests were not always being carried out as regularly as they should, records were not completed in full and not all call points were being tested to ensure they were in working order. We saw several fire doors were propped open or couldn't close properly in the event of a fire. This meant that the provider was not ensuring fire precautions were safe and effective.

There were several commodes in people's rooms which had no rubber bungs on the bottom of the legs. This meant that people were at risk as; if the person put the leg of the commode on their foot they could cause a serious injury or the commode could slip when in use.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they felt there were enough staff to be able to meet people's needs in a timely manner. However, we saw that there were times when people who were at high risk of falling were left alone unsupervised in the lounge area. We also saw that one person who would have benefitted from a member of staff to sit with them to encourage them to eat as they kept walking away from the dining table. We discussed this with the registered manager who informed us that they would look at the deployment of the staff throughout the day.

New staff were employed using safe recruitment procedures to ensure that they were of good character and fit to work with people. Pre-employment checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that staff were of good character and fit to work with people.

The registered manager and staff followed the local safeguarding procedures when they suspected a person had may have been abused. Staff we spoke with knew what constituted abuse and told us they were confident that if they reported an allegation of abuse that it would be dealt with by the management team. There had been no recent safeguarding incidents at the service.

Inadequate

# Is the service effective?

## Our findings

At our previous inspection we had no concerns in the effectiveness of the service. At this inspection we found that the registered manager and staff did not understand the principles of the Mental Capacity Act 2005 (MCA). We found that people's health care needs were not always responded to when people's needs changed or they had lost weight and staff were not always effective in their roles. The provider was in breach of two Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not always receiving care that met their needs and health professionals were not always contacted to ensure people's health care needs were met. We saw that people were regularly weighed monthly, however we saw two people had lost weight over a period of eight months and no action had been taken to refer the people for health advice and support. This meant that the provider was not always working with other agencies to ensure a holistic approach to people's care.

We saw records that confirmed that one person had been prescribed medicated bathing oil for sore skin. The person's care records stated that the GP had said that the person should have at least two baths a week in the oil. We looked at this person's records and saw that they had not had a bath at all. A member of staff told us: "We use the oil on a flannel and wipe the person down with it when we give them a strip wash". This meant that this oil may not be fully effective as they were not following the GP's instructions.

One person's mental health had deteriorated and they had become increasingly anxious. The person had been prescribed anti-psychotic medication to help them to remain calm. However no further support for the person had been gained to ascertain why the person may be more anxious including ruling out any underlying health conditions. We also saw two people who had long toenails which required cutting and alerted the registered manager who told us they would ensure they saw a podiatrist. This meant that health care support was not always gained in a timely manner to ensure people remained healthy.

We saw another person would have benefited from assistive technology such as a sensor mat to support them to remain safe and independent as they had been falling regularly. This person had not been referred for professional health support and the registered manager told us that the provider would not pay for the technology. This person continued to be at risk of harm due to the lack of equipment to promote their independence.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The 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. A proportion of people who used the service were living with dementia and required support to consent to their care at the service. People's mental capacity to consent to their care had not been assessed effectively

and there was conflicting information in people's care records. For example, one person's care records stated 'I can make decisions for myself. I know what I want'. Yet the person had a Do Not Attempt Resuscitation (DNAR) order in place which had been signed by their GP who had recorded that the person did not have mental capacity. This meant that people were at risk of not consenting to their care and support when they were able to as their assessed needs were not recorded correctly.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw a locked shower room and the registered manager told us that it was locked to prevent one person going in there, they had not considered that this was a DoLS for this person and other people wanting to enter the room. We asked the registered manager which people had a DoLS authorisation in place and which people had been referred for an authorisation and they were unable to tell us although they were aware that some people did have authorisations. This meant that people may be being unlawfully restricted within the service as the registered manager and staff did not know who was subject to a DoLS and who required a referral for a DoLS.

These issues constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a mixture of views on the quality and quantity of food and drinks. Several people told us they were not offered enough to drink. One person told us: "The food is like home cooking and I enjoy it but the drinks are a bit on the thin side, I don't get as much to drink as I would like, if you ask for drinks it doesn't always go down well." Another person told us: "The food here is not to my taste but they will do me something different I suppose". Another person said: "I would like a hot drink. The food is ok but I can't always eat it". At breakfast we saw people were offered cereal and toast. We saw it was white bread only and there were no jams or preserves set out for people to be able to help themselves to. One person told us: "I like porridge but I wouldn't ask for it". There were two options for main meal and we saw that two people who were assessed as requiring finger foods received this.

Staff told us that they received support and training to be effective in their roles. The registered manager did show us that all staff were being supported to complete the care certificate and we saw that this had just begun. However, we saw that staff did not always implement their training they had received so that they were effective in their roles. For example, the cook did not follow safe food and hygiene and infection control procedures although we saw they had received training in them. The registered manager was unable to tell us why they had not addressed this issue and they were unable to show us what training other staff had received as there were no training records kept.

Some areas of the environment required decoration as areas were unkempt and looked worn. The dining tables were old, with old worn cutlery in use. There were no placemats or condiments set out for people. The dining experience did not support a setting conducive to a pleasurable mealtime. Good practise guidelines in the care of people with dementia were not evident through the service. NICE guidelines state; When organising home placements for people with dementia, health and social care managers should ensure that built environments are enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment. We observed that the environment did not support people to orientate to time and place.

Inadequate

# Is the service caring?

## Our findings

At our previous inspection we had no concerns about how people were treated. At this inspection we found that people were not always treated with dignity and respect. We found the provider was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not being offered or having regular baths and showers. Staff had recorded on people's personal care records that people had been strip washed or bed bathed. We discussed this with the registered manager who told us this was an issue with staff recording incorrectly. However, we saw that several people had commented on a 'resident's survey' that they wanted to have baths and showers and many people were not actually being bathed or showered at all. This did not demonstrate respect for people as their personal care needs were not being met as they wished.

One person was unable to communicate with staff in a way in that they would understand due to cultural differences. No communication tool had been implemented to help staff understand the person and the person to understand staff, yet this would be easily achieved through pictures and research. This person was being administered regular anti-anxiety medication as they were showing signs of agitation and calling out. This meant that this person's diverse needs were not being considered in relation to their communication and the reasons for their agitation.

We observed that all the female residents did not have hosiery on and their legs were bare. We discussed this with the registered manager who told us there was no reason why these people did not have anything on their legs and this was a lack of attention to detail from staff supporting people.

One person was complaining of being cold. We saw they were sitting next to the conservatory door which was cold and staff were coming and going through it and creating a draft. Staff eventually went to get the person a blanket which we observed was tatty and was the property of the hospital. This did not demonstrate respect for this person as the staff had taken time to notice the person was cold and the blanket did not belong to the person themselves.

We saw one person who was living with dementia had left the dining table and forgotten that their meal was there. They asked a member of staff for their meal and the staff member replied in an inpatient manner: "Your dinner is on the table". They did not attempt to show the person their dinner or sit with them whilst they ate it. This did not demonstrate a respectful manner to respond to this person.

People all had their own private rooms, however one person told us: "The staff don't like you staying in your room. I do go to my room and if they see me go they bring me back because they want me in the lounge where they can see me". We saw that it was recorded in another person's risk assessment that they needed to be in the lounge so they could be observed. We discussed this with the registered manager who told us this was to prevent these people from falling. No action had been taken to ensure that people could spend time alone safely.

People were able to have visitors to the home. We saw several visitors on the day of the inspection. However one person's relatives told us that they had been made to feel uncomfortable visiting as they had complained about their relatives care. We discussed this with the registered manager and they agreed that a resolution to this issue should be found to ensure that the person who used the service was not upset by the atmosphere created. Another person told us: "We like the conservatory it is nice to sit in but it is very cold in there now. We like to sit in there to talk to our relatives about personal things you don't want them to hear and there are always interruptions. There is a heater in there but they never turn it on. I think it should be turned on for us." This meant that people's visitors were not always made to feel welcome and people's right to privacy was not always considered.

These issues constitute a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Several people told us they were happy with the care they received at the service. One person told us: "I am very pleased with the care here I am well looked after. The staff are polite and kind and always helpful and I don't really have any grumbles." Another person told us: ""I am ok, I am just happy. I have my TV. The staff are good and look after me they are good to me". A relative told us: "We are very happy with the care here we have no complaints we come for an hour every week".

Requires Improvement

# Is the service responsive?

## Our findings

At our previous inspection we had concerns that people were not receiving care that met their individual preferences as they were not always receiving a bath and a shower as often as they liked. Since the last inspection we found that the registered manager had devised a form stating people's wishes in relation to bathing; however we found that people were still not receiving a bath or shower as often as they would like.

People had individual care plans and information was gathered with the person themselves where able to, family members and other relevant people in the person's life. We saw information on people's cultural background and religion and diet. One person was unable to speak English and this was recorded in their care plan, however no communication tool had been put in place to support staff to be able to communicate with the person. A relative of the person told us: "My relative misses speaking in their own language and gets very upset they cannot be understood properly". A member of staff told us: "I've thought about putting something together but just haven't got around to it". The registered manager told us that for important decisions and discussions an interpreter would be arranged; however on a day to day basis nothing had been implemented to help the person communicate their needs.

This was a breach or Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation's 2014.

The provider had a complaints procedure and we saw this was visible in the reception. However one relative told us that they felt they had been treated less respectfully since lodging a complaint. The relative told us and showed us that they had made four formal complaints which had been made in writing to the registered manager and they had not received a response. We discussed this with the registered manager who was unable to explain why these formal complaints had not been responded to. This meant that people did not feel able to complain and their concerns and complaints were not being acted upon.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's wishes in how they wanted to be cared for at the end of their life had not always been sought. Although we some people had a DNAR order in place, other preferences had not been discussed with people. The registered manager told us that people and relatives usually responded by stating they did not want to discuss this and would discuss their wishes at a more appropriate time. The registered manager told us they liaised with other health care agencies to support people to be comfortable and pain free when people were coming to the end of their life.

People were supported to participate in hobbies and activities of their choice. There was a day care centre facility in site which people in the community were able to access. There was a designated day activity coordinator who arranged activities and outings into the community. We saw people were offered the opportunity to participate but if they chose not to this was respected.

Inadequate

# Is the service well-led?

## Our findings

At our previous inspection we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the systems they had in place to monitor and improve the quality of the service were not effective. At this inspection we found that the systems were still not effective and people were receiving care that was not safe, effective, caring, responsive or well led.

A recent resident survey had identified that several people had said they were not having a bath or shower as often as they liked and we saw that staff had recorded clearly on personal care records that people had been supported to strip wash or have a bed bath and not bathe or shower. The registered manager told us they were unaware that this had not been happening. This had been identified at our previous inspection and no action had been taken to monitor people's bathing. This meant that the system to monitor personal care was ineffective.

We found that analysis of accidents and incidents was not effective and did not reduce the risk of them occurring again. Some people had experienced falls and received injuries yet no effective action had been taken to prevent the incidents from occurring again.

People's care plans and risk assessments were reviewed monthly by a senior member of staff. However we saw that these reviews were not effective. For example we saw one person had been falling regularly over a period of months, yet their falls risk assessment review stated 'no issues' as they had not linked the falls to the review. This meant the person's risk assessment was not updated to reflect the fact the person had fallen and did not reduce the risk of it occurring again.

The infection control audit had identified that several new mattresses were required as they were soiled. However the mattresses had not been requested from the provider in a timely manner to reduce the risk of infection.

We saw the health and safety audits and maintenance report did not cover people's bedrooms only the communal areas. We found that some people's rooms required maintenance, for example one person's flooring was ripped and could cause a trip or infection hazard and we saw several commodes required maintenance to ensure safe usage. It was unclear as to whether these improvements had been noted and were in the maintenance programme.

Fire checks were not being carried out effectively. We saw that system was not being checked as regularly as it should be and had not been effective in identifying several fire doors which did not automatically close. This put people at risk in the event of a fire.

We saw that there was an audit of the call bells and the length of time they had rung before being responded to. The records stated 'the call bell should ring no longer than 60 seconds' ,however we saw there were several recorded calls that had rung over 60 seconds and no action had been taken to identify why this had occurred. This audit was not effective in improving call times.

There were no comprehensive training records for staff and the registered manager was not able to tell us which staff had completed which training. This meant that there was a risk that staff may be performing tasks they were not trained to.

The registered manager was not aware of who had a DoLS authorisation or referral as there was no system in place to monitor. This meant that people may not be receiving care that was safe, lawful, and met their needs.

These issues constitute an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider was in breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 as they were not notifying us of expected death and unexpected deaths. Since the last inspection we had received notifications when required and the provider was no longer in breach of the regulation.

Following the inspection the registered manager informed us that the required mattresses had been replaced and they had implemented new systems to monitor and improve the quality of 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 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive care that met their individual needs and prefrences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not always treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The principle of the MCA 2005 were not always being followed. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not always receiving care that kept them safe from the risk of harm. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>People's complaints were not always acted upon. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The systems the provider had in place to monitor and improve the service were not effective. |