

# Central and Cecil Housing Trust

## Rathmore House

### 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?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



### Overall summary

This unannounced inspection took place on 23 April 2015. Our previous inspection took place on 7 March 2014 and we found the service met the regulations inspected.

Rathmore House is a residential home specialising in dementia care for up to twenty people over 65 years of age. The home is situated in a residential area of Swiss Cottage, North London.

There was a registered manager was in place at the time of our visit. 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.

Documentation at the service stated that risk assessments should be reviewed monthly but in the files we saw that documentation did not support this. Some reviews that were undertaken were not specific and did not include all the relevant information relating to that specific risk or need being reviewed.

Forms we saw requiring people to consent to care and treatment were not signed by them or an appropriate

# Summary of findings

legal representative. We also noted that the documentation in some care files regarding the development of care plans, were not signed by people who use the service or other parties to confirm any involvement in the process. We saw that 'Do Not Attempt Resuscitation' (DNAR) forms that were used for recording resuscitation decisions were not recorded on the correct forms.

Some assessments and information on care files were incomplete. Some reviews of risk assessments were not specific." Reviews, including reviews of care plans, were not carried out monthly as stated in the documentation at the service. This meant that any changes to the way people needed to be supported safely may not have been identified effectively and may lead to inappropriate and unsafe care being provided.

A complaints log was completed but we did not see evidence of feedback regarding the outcome of the complaint being given to people or their relatives and there was no information to indicate if they were satisfied that the complaint had been resolved effectively.

Monthly care plan and risk assessment reviews were not being audited effectively and had not identified the shortfalls found during the inspection.

Staff had received training in safeguarding adults and we saw a safeguarding adult's policy in place. Staff were aware of what constituted abuse, the types of abuse and the steps to take if they were concerned.

We found suitable numbers of staff to support people on each shift. There were recruitment procedures in place to help ensure people were safe and not at risk of being supported by unsuitable staff.

There were systems in place to ensure that people consistently received their medicines safely, and as prescribed. Weekly medicine audits were undertaken.

We saw evidence that a fire safety risk assessment had been completed and weekly fire alarm testing had been undertaken.

Senior staff had a good understanding of the Deprivation of Liberty Safeguards (DoLS) process and had actively

referred people to the local authority for a DoLS authorisation. DoLS exist to protect the rights of people who lack the mental capacity to make certain decisions about their own wellbeing. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way.

Staff had the knowledge and skills needed to perform their roles. There was an induction programme in place for new staff that covered training in mandatory areas such as, health and safety, moving and handling, fire safety, safeguarding adults and food hygiene.

Staff had received one to one supervision at variable intervals ranging between monthly and six monthly. One staff record we saw had a recent appraisal recorded. An appraisal is an overview of the year's work performance, training and development and should be conducted annually for all staff.

People's nutritional needs were assessed and recorded in their care files and menus we saw indicated they were receiving a balanced diet.

People were supported effectively with their health needs. The GP visited once a week and more often if staff requested. Relatives and visitors told us that their relatives and friends were able to see the GP when they needed.

We saw that thought had gone into the physical environment to support independence and to aid familiarity, particularly for people with impaired memory. Staff completed life histories with people and told us they used the information to ensure equality and diversity was upheld.

We saw some evidence of activities at the service but some people in the session did not appear to be engaged in the activity being presented.

People and their relatives felt confident to raise any concerns they might have with the care workers and the managers.

# Summary of findings

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

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe. Reviews of risk assessments were not always specific to people's needs and were not reviewed monthly.

Staff were aware of how to safeguard people and the steps to take if there was a concern about abuse or harm.

There were sufficient numbers of suitable staff to keep people safe. Weekly medicine audits were undertaken to ensure the safe administration of medicines.

**Requires improvement**



### Is the service effective?

The service was not always effective as forms were not always signed to consent to care and treatment.

Staff had a good understanding of the Mental Capacity Act 2005 and supported people to make day to day decisions in line with the principles of the act.

Staff had undertaken induction training as well as a number of mandatory training courses.

Staff were aware of how to support people to access healthcare services effectively.

**Requires improvement**



### Is the service caring?

The service was caring. Staff showed patience and understanding whilst supporting people and encouraged people to be independent.

Life histories were used to ensure equality and diversity was upheld by understanding people's unique preferences and needs.

**Good**



### Is the service responsive?

The service was not always responsive. Information in care files was not always recorded and some information was incomplete. Care plans were not always reviewed monthly as stated in the documentation at the service.

Care plans for communication and social wellbeing aspects of care, contained clear information on how to maximise communication with people.

Meetings were held for people, their relatives and friends to provide opportunities to raise any issues of concern and staff used it as an opportunity to address issues in a timely way.

**Requires improvement**



### Is the service well-led?

The service was not always well led. Quality assurance monitoring was not always effective as it had not highlighted that risk assessment and care plan reviews were not being undertaken for people on a regular basis.

**Requires improvement**



# Summary of findings

Staff were supported by the management and received clear guidance. There were mechanisms in place to feedback through staff surveys that informed service development.

Accidents and incidents were recorded appropriately and appropriate action was taken to address any issues.

# Rathmore House

## 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 April 2015 and was unannounced. The inspection team included an inspector a specialist nurse advisor, with experience of dementia care 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.

Before the inspection we reviewed the information we held about the service, including all notifications the provider must send to us about significant events.

During the visit we spoke with eleven people that use the service, three relatives, one volunteer, three care workers, one senior care worker, the deputy manager and the area manager. We observed the care and support offered to people who used the service during the time of our visit as well as speaking with four visiting professionals.

We looked at a sample of four care records and four staff records, reviewed records of checks relating to the management of the service and looked at policies and procedures. We checked records of team meetings, complaints and premises maintenance.

We also gained feedback from health and social care professionals who were involved with the service as well as commissioners and we also spoke with the Human Resources Business Partner and the training officer for Rathmore House.

# Is the service safe?

## Our findings

People and relatives told us they felt Rathmore House was a safe service. We saw an interaction with a care worker and a person in a wheelchair wanting to use the garden. The sun was fairly hot for April and the carer raised a table umbrella to give shade. The care worker made sure the person was safe and comfortable.

Staff had received training in safeguarding adults and we saw a safeguarding adult's policy in place. Staff were aware of what constitutes abuse, the types of abuse and the steps to take if they were concerned. One person said, "I would report such matters to the person in charge the Manager or Head Office." Another told us that policies relating to safeguarding were located in the office and they could access these at any time. They also felt confident to contact the local authority or the Care Quality Commission, if they felt that no action was being taken. There was a whistleblowing policy in place and staff were aware of its purpose and how to use it.

We looked at staff rotas and we found a suitable amount of staff to support people and keep people safe on each shift. This was reflective of the amount of staff on duty on the day of our visit. All bedrooms were fitted with a call bell system. Panels were generally attached to the bedside cabinet for ease of access. The system also had pendants for people to wear; these were usually provided for people who were more at risk of falls or may need urgent assistance.

Care records contained risk assessments, such as moving and handling, medication, environment and, on one care record, we saw relevant information relating to the risks of a person's going out of the home.

Documentation stated that risk assessments should be reviewed monthly. However, the documentation in the files we reviewed did not support this. Some reviews that were undertaken were not specific and simply stated 'updated'. They did not include the relevant information relating to specific risks. On one care record there was no specific information about how they had reviewed the risk around moving and handling and on another, we saw that a 'Waterlow' score (which is used to assess the risk of a

person developing pressure ulcers) was incomplete. This meant that any changes to people's needs may not have been identified and could lead to unsafe and inappropriate care.

This is in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We were told by the managers that there were some staff vacancies that were being covered by a specific agency, organised by head office. To provide continuity of care, the home tried to use agency staff that had worked at the home before. Dependency levels were monitored on an ongoing basis to ensure there were sufficient staff to support people throughout the day and night. The area manager confirmed that they were aiming for a five to one ratio of care staff to support people during the day.

There were recruitment procedures in place to help ensure people were safe and not at risk of being supported by unsuitable staff. We looked at the recruitment records for four staff and found that all had evidence of an application form, two references, and proof of eligibility to work in the UK. A Disclosure and Barring Scheme (DBS) check had also been completed to ensure people seeking employment were not barred from working with adults at risk.

We observed part of the morning medicine administration. Medicines were usually administered by senior care staff. In response to a recent risk assessment, a registered nurse had been employed through the provider's preferred agency to administer nighttime medicines. However, we saw no evidence of competency checks for medicine administration for nurses employed via this route. This was discussed with the area manager and deputy manager, who agreed to request evidence of checks immediately.

We saw that the Medicines Administration Records (MARs) had clear photographs for identifying the person, with any known allergies recorded. This provided extra safety as it was checked against the MAR chart, and once the person has taken the medicine, the MAR chart was signed. Medicines were administered using a non-touch technique. There were no homely remedies stored at the service and all medicines that were given as required were stored and administered appropriately.

Creams were recorded on a separate sheet. This had a body map outline to indicate where the cream should be

## Is the service safe?

applied and indicated the frequency, type of cream/ ointment to apply. We noticed occasional gaps in recording of creams application on two charts. This was reported to the deputy manager and area manager.

There was evidence of weekly medicine audits since February 2015. Any issues identified were highlighted in red ink. In the event an error being identified, staff informed us that this would be seen by managers and they would expect an explanation regarding the reason for the error. We saw no gaps on the MAR charts.

A medicine audit conducted on 13 March 2015 had identified several issues and actions had been taken to address the identified concerns. The supplying pharmacist had also conducted a recent audit and as a result of their findings actions had been taken to improve practice. This included MAR charts being checked twice daily at handover by the Senior Care Staff, as a further safeguard.

The medicine policy was dated 2012. Staff had signed to confirm that they had read it. The signatures were dated April 2015. The medicine procedure was also dated 2012.

**We recommend that the service regularly reviews the medicine policy to incorporate changes in legislation and good practice.**

We saw evidence that a fire safety risk assessment had been completed on 14 July 2014 and weekly fire alarm testing had been undertaken. On each floor we saw evacuation slides for use in the event of a fire. Fire extinguishers were located throughout the building as were fire instructions. Personal evacuation plans were seen in the care files we looked at.

Radiators we saw had covers as a safety precaution, and windows were restricted. Health and Safety posters were on display with a named person for Health and Safety written on it. Staff were seen to wash their hands and use protective clothing and gloves appropriately.

# Is the service effective?

## Our findings

Staff had the knowledge and skills they needed to perform their roles. One person said, “Some staff are good and some are not.” A relative visiting told us, “They responded very quickly when our relative had a fall. They didn’t see the fall but they saw some blood and called the doctor and then called us. They reported themselves when there was a mix up with some medication for her tummy. It was not important.”

Staff told us they had an induction programme when they started work at the service that covered training in mandatory areas such as, health and safety, moving and handling, fire safety, safeguarding adults and food hygiene. One care worker, who had recently joined the organisation, confirmed that they shadowed a more senior member of staff before they felt confident to work alone. They also stated they were working towards a level two diploma in health and social care. We spoke with the training officer for Rathmore House and saw records of the training completed by staff as well as planned dates for refresher training. This was organised centrally from the provider’s main office. One staff member told us of the use of role play during group supervision as a way of understanding how people who use services feel, for example, when there using the hoist and for understanding sensory impairment.

We spoke with staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. Staff had received one to one supervision at variable intervals ranging between monthly and six monthly. One staff record we saw had a recent appraisal recorded and two others were new staff and the appraisal hadn’t been scheduled. We saw the content of supervision sessions recorded were relevant to the persons work and included topics such as safeguarding, health and safety as well as training updates and requirements. Staff confirmed that supervision session took place every three to six months and they found them useful and supportive.

Care staff we spoke with had a good understanding of the Mental Capacity Act 2005 and the principles in terms of supporting people to make day to day decisions, for example about the clothes people wear and the food they eat. However, the forms we saw requiring people to consent to care and treatment were not signed by them or an appropriate legal representative.

Although people’s and their relatives views had been sought in developing care plans, in the three care files we looked at we noted that the documentation concerning the development of care plans were not signed by people who use the service or other parties to confirm any involvement in the process.

In two care records we saw the ‘Do Not Attempt Resuscitation’ (DNAR) forms used for resuscitation information and decisions, were not recorded on the required forms. This was discussed with the deputy manager who confirmed he would be contacting the GP as soon as possible in order to rectify this.

**We recommend that forms seeking consent to care and treatment are signed by people in advance of care and support being provided. If people lack capacity to consent then appropriate steps, including best interest decisions, should be taken in line with the Mental Capacity Act 2005**

The deputy manager and senior care worker had a good understanding of the Deprivation of Liberty Safeguards (DoLS) process and had actively referred people to the local authority for DoLS authorisations. DoLS exist to protect the rights of people who lack the mental capacity to make certain decisions about their own wellbeing. It also allows people’s movements to be restricted for their own safety. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way. We saw one person required additional care which was provided through one to one support. In their care records it stated they had been seen by the community psychiatric nurse, a best interest assessment had been carried out and a standard DoLS authorisation was in place. This identified possible risks, including safety, self-neglect and possible exploitation.

People’s nutritional needs were assessed and recorded in their care files. They also contained information about the person’s food likes and dislikes, where they liked to eat, and how they liked food to be served. Menus offered a balanced diet. At a mealtime, we saw people were being offered a choice of food. The food was well presented and we saw that people’s dietary requirements were catered for. One person said “The home always provides me with good vegetarian meals”. People told us they enjoyed their meals and we observed people being supported to eat and



## Is the service effective?

drink in an unhurried way. In one care file we saw guidance regarding a person's swallowing difficulties and need for a soft diet. The speech and language team had undertaken an assessment in 2014 and provided guidance for staff. We saw that the person received a soft diet and was supported appropriately.

We saw that food and fluid charts were not always totalled at the end of the 24 hour period, therefore making it difficult to assess whether people had sufficient fluids to prevent dehydration. On some charts the entries for the evening and overnight period was limited. We discussed this with the area manager and deputy manager who confirmed that action would be taken immediately to ensure people's food and fluid intake were recorded appropriately and accurately.

People were supported to access the health care they needed. The GP visited once a week and more often if staff

requested. Relatives and visitors told us that their relatives and friends were able to see the GP when they needed. Care plans also showed that other health professionals, for example, dentists, opticians and chiropodists had been consulted about people's needs. Copies of appointment and discharge letters from the hospital were kept in people's care files.

During our visit, we spoke with a visiting community dentist who said they had come to carry out screening for some people and that their service aims to see people within a month of a referral being made. We also saw a visiting nurse who told us she came every day to change dressings and check the blood sugar levels of people with diabetes. A privately arranged physiotherapist who was visiting told us, "Care staff are always willing to be shown and follow the instructions I leave for them."

# Is the service caring?

## Our findings

People told us that staff treated them with compassion and kindness. One person said, “The staff are good, we have a good chat and a good laugh together too.” Another said, “I think they are good, yes, on the whole.” Carers interacted kindly with people and appeared to know and anticipate their preferences. One care worker said to someone as they were offering them a hot drink, “You like chocolate biscuit with your tea, yes?” They appeared familiar with what the person liked.

Health and social care professionals we spoke with told us that care staff were patient and respectful and that they were always attentive to people’s needs.

We observed several people having conversations with staff or one another. We witnessed staff showing patience and understanding with people, calling them by their preferred name and generally understanding their needs. One staff member was trying to and succeeding in encouraging a person to mobilise using their walking frame for a short distance between the dining area and the foyer seating area. The care worker was encouraging the person every step of the way, constantly saying “You’re doing well just a few more steps, you are doing so well.” At the point when they reached the seating area, a chair was placed gently behind them so that they could sit down and once they were comfortable, a cup of tea was brought and placed within their reach. The care worker encouraged the person throughout and was close to them, gently guiding and supporting them.

We saw that much thought had gone into the physical environment to support independence and to aid familiarity, particularly for people with impaired memory. Chairs were grouped and arranged in the sitting room to

provide different areas and there was easy access to the garden. Walking frames were kept mostly out of the way when they were not in use and some people kept them close by.

Domestic, homelike signage was present to promote orientation and bathrooms, toilets and shower areas had clear signs. There were electric display boards, which automatically changed to the correct day and time of the day i.e. afternoon or morning. Doors to people’s rooms were made to look like front doors and memory boxes outside each room were used to keep familiar items for people.

Staff knew how to support people to express their views and be actively involved in decision making as far as possible. They had completed life histories with people and told us they used the information to ensure equality and diversity was upheld. One staff member told us they sit down with people and have one to one discussions about their lives and share experiences, such as discussing what jobs they used to do and if they observed a particular religion. Staff told us they had celebrated the Islamic festival of Eid last year as they discovered some people were used to doing this before they came to the service.

Staff told us that people, or their representatives, were asked about their preferences on admission to the home and that this was recorded in people’s care plans to ensure they were upheld and respected.

We saw evidence that people and their relatives had been involved in decisions about the development of their care plans and received feedback about changes to care and support where appropriate. Care plans contained information about people’s preferences regarding their care. People’s likes and dislikes regarding food, interests and how they wanted to spend their time were also reflected in their care plans.

# Is the service responsive?

## Our findings

People and their relatives had been involved in the pre-assessment process before coming to the service. This assessments contained information on personal care needs, social care needs, beliefs, mobility, hearing, vision and medication. Where appropriate the home also received an assessment from the funding authority. Life stories were completed either by people using the service, families, care staff or with input from them all. Care plans included information about the person's life which was used to see to understand people's individual needs and preferences.

However, on one care file we saw, a person's weight had only been recorded once since admission, despite it stating that weekly weight checks were needed. Other assessments and information we looked at were also incomplete including, the Body Mass Index (BMI) and dietary requirements sheet, and manual handling, although the person was seen to be mobile, and staff confirmed they were fully mobile.

This is in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The care files contained personalised information for staff to refer to. End of life care information was explicit in the files we saw, and in one it was recorded that the person did not wish to discuss it at the time of asking. In another care file saw there were specific instructions regarding a person's needs in relation to their religion and faith and this was recorded. There was good information for staff to use regarding death and dying and the specific needs that must be addressed with different cultures and faiths, in their death and dying policy.

Care plans for communication and social wellbeing aspects of care, contained clear information on how to maximise communication with people. Information referred to simple sentences, the use of eye contact, body language, use of pictorial signs and communicating in both languages where appropriate.

The 'daily record' was completed by care staff who recorded the activities undertaken for each person on a daily basis. This included the person's food and fluid intake, personal care delivery, for example, if the person had a

bath, shower or wash as well as monitoring general observations. Staff told us they used the information to see how people were doing and to respond to any changes that may indicate a decline in a person's wellbeing.

We saw an activity board displayed prominently in the communal area at the entrance of the building. It showed the activities for each morning and each afternoon. Reminiscences style items such as the television and radio were in the ground floor foyer area and a separate lounge area where the TV was on. There were daily newspapers, which were either at the individual's own request; or a selection of general newspapers in circulation.

One visitor said, "When you come here the staff are always doing something purposeful, cheerfully with residents". Other visitors told us they liked the guest area in the entrance hall and that it looked very good and tasteful. Another told us that they were surprised and pleased that their relative enjoyed karaoke sessions at the home; something they would not have imagined. They also said "It would be nice if there was "more reading aloud." Their relative had had a volunteer reader from a voluntary agency for six weeks but that was now over and they missed it. One visitor told us that the visiting hairdresser had not been to the home for around six weeks. We were told by the senior staff that the hairdresser had moved out of the area but they were in the process of arranging for someone to come over from one of their other residential homes in order to continue to provide a service.

We observed a music playing session which a volunteer had come to deliver. It seemed to be delayed by the unexpected provision of a chair yoga session, which was not detailed on the activity board. There were twelve people in the room, who seemed to be expecting to listen to music finding themselves being asked to breathe and raise their arms. Only three out of twelve people assembled joined in. The area manager told us that yoga was more established and a popular activity in other homes.

The last resident and relatives meeting was held on 29 January 2015 and the deputy manager told us that letters were sent out in advance to give people notice. We saw that people and their relatives were given an opportunity to raise any issues of concern and staff at Rathmore House used it as an opportunity to address issues in a timely way.

People and their relatives we spoke with told us they were confident they could raise any concerns they might have

## Is the service responsive?

with the care workers and the managers. Care workers we spoke with told us they would ensure that all concerns they received from people or their relatives would be reported immediately to seniors or the manager in charge.

A complaints log had been completed. However, the home could not provide evidence of feedback regarding the outcome of complaints being given to people or their relatives and there was no information to indicate if they were satisfied that the complaint had been resolved effectively. Information on how to make a complaint was not displayed in any of the communal areas of the building.

**We recommend that details of the complaint, any action taken and the outcome are recorded on the complaints log. Information on how to make a complaint should be accessible to people using the service, their relatives and friends, including being available in an accessible format and displayed in a communal area at the service.**

# Is the service well-led?

## Our findings

People using the service, their relatives and friends were positive about the registered manager and way the provider ran the service. One person told us, “The manager and the staff are very efficient.” A visitor told us, “The manager is fantastic. Relatives told us they felt confident to speak to the registered manager about any issues that arose and that it would be resolved.

We saw that monthly care plan and risk assessment reviews were not being carried out in accordance with the documentation at the service. A monitoring visit conducted by the local authority in January 2015 also raised concerns regarding care files and care plans not being reviewed. Audits were not being carried out effectively. The concerns raised by the local authority had not been addressed. This meant that regular checks to ensure the delivery of high quality care were not taking place and people were at risk of receiving inappropriate care and support.

A general risk assessment of the building had been conducted in 2013 and a review was due to take place in 2014. However, the home was not able to demonstrate that this had taken place.

This above information is further evidence of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that feedback from people was sought via residents and relatives meetings and a service user survey had been undertaken in 2014 and results were generally satisfactory. The area manager informed us that results were being collated and would be used to improve and develop the service.

Staff were positive about the management and told us they appreciated the clear guidance and support they received. One said, “He’s a good manager, gentle and supportive”. Another said, “The manager is good and we also get support from the deputy”.

A staff survey had been undertaken in 2013 and the feedback was used to inform the work around the Investors in People Award in 2014. A number of initiatives were planned as a result, for example, employee wellbeing road shows for staff and introducing a yearly care conference.

Accidents and incidents were recorded appropriately and action had been taken to address any issues. There was evidence that an annual fire safety check had been completed on 14 July 2014

Health and social care professionals we spoke with told us they thought it was a well-run service and that the managers and staff worked well with other agencies to make sure people received their care in a joined up way. They told us they thought the building was well decorated in a dementia friendly way and that people responded well.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>Risk were not appropriately reviewed and recorded to meet people's needs. The risk assessments did not indicate which risk was being reviewed and how it had been assessed.</p> <p>Regulation 9 (3) (a)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The registered person did not assess, monitor and improve the quality and safety of the services provided, in the carrying on of the regulated activity and securely maintain an accurate, complete and contemporaneous record in respect of each service user.</p> <p>Regulation 17(2) (a) and (c).</p>