Aspire Healthcare Limited

Milldene Nursing Home

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

Summary of findings

Overall summary

This was an unannounced inspection which took place over three days on 23, 26 and 29 January 2016. This is the services first inspection since a change of provider and registration in July 2015.

Milldene Nursing Home is a 13 bed home providing nursing and personal care to older people with mental health needs. There were 12 people living there at the time of inspection, one further person was in hospital at the time of our inspection.

There was a registered manager who had been in post since July 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service also had a home manager who had day to day responsibility for running the service and staff supervision.

The service did not always raise all safeguarding alerts externally with the local authority or CQC. Improvements were being made to the environment and there was a schedule in place for these to be completed. Emergency plans were not in place for possible evacuation or critical events in the service.

Accidents and incidents which occurred in the home had not been reviewed and acted upon to reduce the likelihood of these occurring again. The process for recording and managing these was inconsistent.

Records about staff recruitment were not consistent; there were gaps in records that should have been identified as part of the recruitment process.

People's medicines were managed safely by nursing staff who knew people's needs well and were aware of possible side effects. There was effective joint working with local GP's to promote good health.

People told us they liked the staff team and they were always available to meet their needs. People and relatives felt the staff team knew how to look after people.

Staff were not receiving regular supervisions and appraisals of their performance. Staff training was not up to date and steps had only recently been taken to address this.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw that no one was subject to DoLS, but staff we spoke with were not aware of the process to identify people subject to a DoL. The provider did not have a policy and guidance on DoLS in place.

People told us they felt the staff team were caring and supported them. We observed positive interactions

between people and staff. We saw in care records how people's independence and right to make choices had been considered.

People's care plans and records remained unchanged for a number of years. Reviews were limited and care plans had not changed over time. The provider had not transferred care plans to their own documentation and staff were using the previous provider's documentation and systems.

Complaints had not always been acted upon correctly. Records did show that the registered manager took action to resolve the issues raised by people using the service, but a recent complaint remained unresolved.

The service had failed to notify the Care Quality Commission of a significant incident and staff failed to raise a safeguarding alert with the local authority.

The registered manager held multiple roles within the organisation and much of the day to day responsibility was delegated to a home manager. Quality system checks and audits in the home were not consistent and there was a lack of critical review of the service by the registered manager and home manager. The home manager did not have the dedicated time to carry out their management duties or have full access to the provider's resources.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The service did not have a comprehensive evacuation and contingency plan, or suitable resources in place if an emergency was to occur. The service did not always raise safeguarding alerts externally.

Staffing was organised to ensure people received support to meet their care needs.

There were systems in place to ensure staff were suitable to work with vulnerable people, but records kept were not consistent.

People's medicines were managed well; staff knew how to support peoples mental health needs.

Is the service effective?

Requires Improvement

The service was not always effective. Supervision and appraisal processes were not in place for all staff to receive feedback on their performance and identify further training needs. Staff training was not up to date.

People could make choices about their food and drink and alternatives were offered if requested. There was some issues with the quality of the food.

Staff demonstrated they had an awareness and knowledge of the Mental Capacity Act 2005, which meant they could support people to make choices and decisions where they did not have capacity. Staff were less familiar with the Deprivation of Liberty Safeguards and had not attended refresher training.

Is the service caring?

Good

The service was caring. The staff had a good relationship with people using the service and knew them well.

Staff had the knowledge and experience to respond to the diversity of people's backgrounds and complex mental health needs.

People had been involved in the transfer to a new provider and

were able to influence the service delivery. This had not always been consistent but there was now an improving process in place to ensure people were consulted.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some care plans did not contain the level of detail needed to support people's needs and these needed updating on the new providers documentation.

People had weekly activities schedules in place. Some relatives and people felt there could be a wider range of activities in place.

People and relatives knew how to make a complaint. There were records of responses, but some of the issues had not been resolved.

Is the service well-led?

Requires Improvement

The service was not well led. The registered manager held multiple roles in the organisation and was not always present in the service. The acting manager was not afforded the management time or resources to complete leadership work in the service.

An incident which should have been reported externally and to the Care Quality Commission had not been sent as required. There was limited audit and review of incidents in the service and incident records logs were sometimes inaccurate or incomplete.

Partnership working with external professionals was effective in managing people's behaviour.

Milldene Nursing 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 and 26 January 2016 and day one was unannounced. We spoke to relatives and an external professional on 29 January 2016.

The inspection team was made up of an adult social care inspector.

Before the inspection we reviewed information we held about the service, we had received no notifications from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted commissioners of the service for any feedback. They had some concerns about the service in relation to care records, staff supervision and training and the services environment.

During the inspection we spoke with seven staff including the home manager and responsible individual, as well as three people who used the service and four relatives. We also spoke with an external professional who had regular contact with the service.

Four people's care records were reviewed as were the staff training records. Other records reviewed included: policies and procedures and accidents/ incidents. We also reviewed complaints records, five staff recruitment/induction/supervision and training files, and staff meeting minutes.

The internal and external communal areas were viewed as were the kitchen, lounge/ dining area, bathrooms and, when invited, some people's bedrooms.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. People told us they felt safe living at the service, and felt that the staff team supported them to be safe in the community. One person told us, "It's a safe area, but they go with me when I need to go far as I need someone to help me." Relatives we spoke with agreed, they told us the service was always secure and they felt there were enough staff available to keep people safe from harm. One relative felt the staff had less time to spend with people as staff were more rushed. Relatives were mostly aware of past safeguarding issues with the previous provider, and now felt those matters had been resolved.

Staff we spoke with knew how to raise a safeguarding alert. They were aware of the vulnerabilities the people they supported may have. People accessed the local community shops and some had risk assessments in place to review and manage any possible risks. These included aspects of risk to people's dignity. From records we saw that most staff had not attended safeguarding training or refreshers in the previous 12 months as per the provider's policy.

We looked at incident records and saw there had been an incident between two people using the service in July 2015. The registered manager failed to report this incident to the local authority as a safeguarding alert, in line with the provider's procedure. We asked the home manager about this and they told us this incident had not been reported to the local authority or the CQC. We saw that staff had taken appropriate action after this incident and put monitoring in place to ensure peoples safety.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 Care Quality Commission (Registration)
Regulations 2009 (Part 4).

We looked about the building and found some minor repairs were needed. A lock to the staff room was broken, new radiators did not have safety covers fitted (meaning there was hazard posed by exposed hot surfaces), and first aid boxes lacked items, such as safety pins and wipes. When we brought these to the staff's attention they took immediate action to resolve these.

The provider had a contingency procedure in place. This was not comprehensive as it only gave minimal information about what actions staff should take in an emergency. The list of possible contact numbers for other services had only been partly completed and external agencies, such as social services out of hours contact numbers, were not listed. This procedure was kept in an office and the 'grab bag' the service had in place for evacuation was incomplete, lacking the contact numbers and essential information about people's needs which may have been needed in an emergency. We advised the responsible individual to review this urgently and they agreed to do so.

We looked at accident and incident records completed since the new provider started running the service. The staff were using two different types of documentation to record these; neither were the provider's recognised documentation. From looking at these records we found there was no recorded management action on the forms to state what actions had been take to investigate and reduce the likelihood of repeat

incidents. Forms related to people falling and behaviour directed towards staff or each other. One form was undated and unsigned and had limited information having been completed by an agency worker so it was unclear when this incident had occurred. The responsible individual and home manager were unable to show us the process of review that was followed after each incident. This meant people remained at potential risk of further preventable incidents reoccurring.

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

Staff, people and relatives told us there had been a change to the staffing rota which meant there were two staff on duty through the day, one nursing, and one care. Between 10am and 5pm during the week there were additional staff for cleaning and at weekends a split role carer and cleaner in place. There was a cook employed seven days a week. Relatives did comment that they felt the cleanliness of the service deteriorated at the weekends and some people commented that staff were often rushed and did not have time to spend with people. During our visit we saw that staff had time to respond to people's needs and assist us with the inspection. The home manager stated they would keep staffing under review.

We looked at five staff recruitment files; we found these to be varied in content and completeness. Staff had been subject to police and other pre-employment checks, but records kept of the process were incomplete. Each file had a checklist of expected contents, only one of these had been completed. One file did not have proof of identity checks; another did not have a completed application form on file. One staff member had gaps in their employment which could not be accounted for from the records on file. Another had a reference from an employer whom they had not worked for over five years with no explanation why a more recent employer had not been approached. Staff we spoke with told us they had been subject to interview and appropriate checks before starting employment and we saw that nurse's validation was checked. The home manager told us they had one nurse post vacancy to fill.

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

We spoke with staff who managed medicines and looked at people's records and the storage areas. Nurses were consistent in their understanding of how to order, store and assist people to take their medicines. We observed staff supporting people with their medicines in a respectful manner, as well as involving the person in the decision about when to have 'as and when required' medicines. Medicines storage rooms had temperature checks of the room and fridge carried out and recorded. Nursing staff stated that they had completed appropriate training and had a good knowledge of the impact and potential side effects of medication. Not all creams were dated when they were opened for the first time. When we brought this to the nurse on duty's attention they agreed to act on this in future.

We saw that the service was clean and mostly odour free, although some areas were in need of decoration. We saw that rooms and bathrooms had gloves, aprons and appropriate hand washing facilities, such as liquid soap and disposable paper towels. The home manager showed us a schedule for improvements and decoration to be made to the service over the coming six months. People and relatives commented the home needed re-decoration. We found that mops were not stored correctly, where there was a risk of cross contamination. When we brought this to the nurse on duty and responsible individual's attention they agreed to take immediate action.

Requires Improvement

Is the service effective?

Our findings

People and their relatives felt the service was mostly effective. People mostly told us the staff knew them well, looked after them in a way of their choosing and that they could make choices about how their care was delivered. One person told us that there had been a number of agency staff until recently. They told us the agency staff did not always know how best to support them. They told us, "I had to keep teaching new staff how to help me in the shower, and some of them I had to tell more than once." They told us this was now improved as they had regular staff from the provider's pool of bank workers.

We reviewed the services records on new staff induction and their ongoing staff supervision and training records. We saw that one staff member appointed by the new provider had not completed their induction records. We spoke to this staff member who told us they had completed an induction process and how they had shadowed staff and reviewed records. However this was not reflected in their induction records, which had not been signed off by a manager.

We looked at staff supervisions records and found that since the transfer to the new provider supervisions had not occurred as frequently as the new providers policy stated, which was every three months. None of the records we saw had records of supervisions since June 2015. There were no records of staff having an annual appraisal from the previous provider or since transfer. We discussed this with the home manager who told us they now had a plan in place to restart supervisions and appraisals, but would not necessarily have the time to do this until all nurse vacancies had been recruited to. They told us they would have increased management time once these vacancies were filled.

The staff told us they had only just been given access to the new provider's e-learning system for training. We looked at training records the home manager had from the previous provider. These records showed us that staff had overdue training at the point of transfer to the new provider in July 2015. From talking to staff and looking at records we saw that no update or refresher training had been provided to staff since the transfer. This meant staff had not had access to essential training. The provider sent us a copy of their training matrix, which showed us that training in first aid and fire awareness was overdue for most staff. We asked the home manager to ensure that staff attended overdue essential training as a matter of urgency.

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

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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).
There was no one at the service who was deprived of their liberty. We discussed some of the people living there with staff and noticed they did not have a consistent understanding of what constituted a DoL. There was also one person at the service whose care might have amounted to a DoL. We discussed this with the home manager and noted that no staff had undertaken refresher training in DoLS since the supreme court judgement of 2014 which significantly changed the definition of a DoL. We discussed the one person whose care plan had evidence that they may be deprived of their liberty. The home manager advised this had been discussed at a recent social work review and it was felt they had capacity and had consented to their care plan. The home manager agreed to ensure staff had refresher training in DoLS and to review any potential DoLS with external professionals.

Staff had assessed each person's capacity to make important decisions such as refusing medical advice and interventions. Staff had recorded this in each person's care plan. We saw that people's right to make unwise decisions was recorded, that the person was given the full information to make the decision, and this was respected. Some of these capacity assessments were more than two years old and the home manager agreed to review these to check if the person's condition had changed.

Arrangements to obtain and record people's consent to care were inconsistent. People using the service had not always signed their care plans and some of the care plans were five years old. People told us that staff checked with them to get their permission before carrying out any care tasks. The home manager agreed to ensure that consent was sought and recorded as they transferred to the new providers care plan documentation.

The service had a kitchen and catering staff which prepared all the meals. This was staffed seven days a week and we spoke with the cook who worked five of those days. They told us how they were aware of dietary needs, or of allergies, likes and dislikes from records they held. They told us they tried to speak to each person during the day to confirm what was on the menu, and check if they had any requests. We saw that the menu was posted up and visible and the food appeared appetising and was made from scratch when we visited. However from talking to people and records of resident meetings we saw there was a complaint about the consistency of the food quality over the week. We raised this matter with the responsible person who agreed to look into this further.

We saw that people's weights were monitored. The process of recording had changed and was not in line with the provider's documentation or processes. This meant it was difficult to calculate changes in people's weights easily as only basic details were recorded. We raised this with the home manager who agreed to improve the records.

Staff told us that, by being attentive to small changes in people's mental health and physical care needs, they provided an effective service. An external health care professional we spoke with told us staff referred to them quickly and responded well to guidance and advice. There was evidence on files of regular contact with local GP's and other healthcare professionals, although the recording around this was not consistent. People and relatives told us that staff responded quickly to people's changing healthcare needs and contacted external professionals quickly. Not all external professional visits were recorded consistently and we brought this to the home manager's attention to ensure that all contacts and any feedback were consistently recorded.

Good

Is the service caring?

Our findings

People we spoke with told us they felt the staff team were caring and interested in their welfare. One person told us, "The staff put up with a lot here. Most of them have been here a long time and they know me well and how I like to be looked after." Relatives we spoke with agreed and told us that staff and people living there had a long term relationship which was positive and caring. One relative told us, "I only see (relative) once or twice a week so the staff see them more than I do. The staff know (relative) better than anyone and always keep us informed." Another relative told us that staff did appear at times to be lacking motivation, but that they respected the people living there.

When we spoke with staff about the needs and challenges of working with people they used positive language and were able to reflect upon the changes they had been through together. Some staff we spoke with were very clear that they felt part of a household, with the people living at the service as being the most important part. We saw genuine empathy and warmth expressed by all the staff we spoke with. We saw caring and sensitive interactions between people and staff and there was a relaxed, informal atmosphere. Staff sat with people when they had free time and engaged with them. Staff prioritised people's needs over the inspection process to make sure the service was not disrupted.

We saw from records that people had been involved in the creation of their care plans, and had mostly signed to give their consent. However it was not always clear how they had been involved in any reviews. When we spoke to people they were not always familiar with what was in their care plans or able to tell us how they were consulted. From speaking to families and external professionals they told us their advice and input was requested and they told us that staff tried to encourage people to be involved.

We saw notes of a house forum, or resident meeting. These had only just started again in December 2015 after a gap of seven months; Prior to this they had been roughly monthly. The home manager advised us they would ensure the meetings were happening regularly again and had agenda items for the next meeting. We saw from the last meeting that areas such as activities and menus had been discussed and that actions arising had been followed up and completed. People we spoke with told us the house forum was useful and they felt the home manager acted on any issues they raised.

Some people had a history prior to moving into the service of poor personal care and of self-neglecting behaviours. Staff told us how they worked to encourage people to bathe, change their clothes and dress appropriately to increase their self-esteem. We looked at one care plan where support around continence and dignity whilst in the community had been reviewed to assist the person to access local shops.

Records also showed where staff had assessed peoples capacity to make unwise decisions, giving them information and advice as part of the process. We saw that people had been assessed as having capacity and their choices had been respected by staff and care plans were adjusted accordingly. People's independence and choices were recognised by staff as being important.

Care records were kept secure and staff were able to tell us how they ensured that personal issues were not

discussed in communal areas where they may be over heard. We saw that staff knocked on doors before entering and sought peoples consent before carrying out any care tasks.

We saw that peoples end of life and final wishes had been recorded in care plans. Where people had refused to plan for the future, this was also recorded.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt the staff team were responsive to their needs. One person told us, "The staff know what I'm like. I've been here a long time and they have too." Another person told us, "Now they have more regular staff I feel they are better. I would give them eight out of ten." Relatives agreed that the staff team had managed well over the years to look after their relatives. One commented that their relative could be demanding of time and they felt the staff had managed this behaviour well over the years. Another relative commented that staff were busier now than in the past and were not always as quick to respond as before the transfer to the new provider.

However the care plans we looked at did not always support some of the care that was being offered. Most of the care plans had remained unchanged over a period of two to five years, with little evidence of formal review. Care plans were not always personalised or contained enough detail to guide staff on how best to care for each person. The documentation that was in place was the previous providers care plans, to date no full care plan had been transferred to the new provider's documentation. We saw examples of one that had been started, but this was incomplete and staff were still using the previous provider's documentation for monthly evaluations and reviews.

Records around external professional contacts and advice were recorded inconsistently, with staff using recording forms in a way they were not designed for. Reviews and evaluations were often quite minimal with key information, such as falls, not always being recorded. This meant that new staff would not be able to meet people's needs based solely on the care plans in use.

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

People had individual weekly activities schedules in place. These were in care plans and some were on display in peoples bedrooms. In these we saw that each person had a list of individual and group activities they could take part in each week. Some people did not spend much time out of their bedrooms through choice and we saw that staff encouraged people to eat together in the dining area. We saw that some people accessed local shops and we saw pictures on the corridors of peoples past activities and trips out. It was unclear how often these activities schedules were reviewed.

Staff told us that part of their working week was to support each person with their activities schedule as required. Recording and review of activity was at times limited so it was unclear how these were evaluated. However people we spoke with told us they were sometimes a bit bored and relatives we spoke with all felt that more activities in the home would be a positive change. Activities was a regular agenda item on the house forum minutes of the last two years. We discussed this with the home manager who agreed to review activities further through the house forum.

We looked at the services complaints records. We saw there had been two since the transfer to the new provider. These both had response letters on file and had been responded to quickly. We spoke with one of

the people who had complained and they told us they did not feel the issue had been resolved. They felt the solutions offered in the response letter had not been acted upon and the issue remained unresolved. The registered manager had not ensured the complainant was satisfied with the outcome or offered them a chance to escalate the complaint further if they remained unhappy with the outcome. We spoke with the responsible individual who agreed to action this further and seek a resolution.

Requires Improvement

Is the service well-led?

Our findings

People told us they liked the home manager and knew them well. Not all the people we spoke with were familiar with the registered manager. Some relatives and the external professional we spoke with told us they had not met the registered manager and only dealt with the home manager or staff. People and relatives we spoke with told us they had been anxious about the transfer to a new provider. They all told us that the transfer to the new provider had worked mostly well. They told us there had been some changes in staff and in the hours worked, and noted the staff had less time to spend with people.

However the staff we spoke with had varied views about the effectiveness of the services leadership since the transfer. Staff told us they had not been supervised as regularly as before and that they had not been able to access the provider's e-learning to date. Staff told us they felt there had been a reduction in leadership in the home, as the registered manager was not visible in the service and the home manager was covering nursing shifts until vacancies were filled. Staff told us that a number of issues, such as the homes decoration and the transfer to the new provider's documentation had stalled.

We asked the responsible individual about the transfer to the new documentation and they told us their quality lead had worked with the staff team in 2015 to develop this. This process appeared to have not progressed as intended. They agreed to review this further with the registered manager. The responsible individual told us their intention was to develop the home manager to take on the role of registered manager. The present registered manager was registered manager at another location and acted as an area manager for the provider. We discussed the decoration and improvements to the home with the home manager and they showed us an action plan which covered the next three to nine months. This planned that all the items would be resolved in that timeframe.

The issues about staff supervision, access to training, the transfer to new care documentation and improvements to the fabric of the home had not been resolved in the first six months after transfer to the new provider. The issues had not been progressed and it was felt by staff that this was because there was a lack of adequate leadership.

The home manager told us they had only recently gained access to the providers IT system for logging quality audits (SharePoint), as well as access to their e-mail system. They had only just been able to access the provider's e-learning for staff.

Accident and incident records had not been reviewed and records did not show any actions had been taken to learn from these incidents. Some of the records were incomplete and the part of the form that was to be completed by the manager were mostly blank. The service did not have a process in place to monitor the services quality and take action as required to improve.

There had been two staff meetings since the transfer to the new provider. In the meeting of 17/11/15 it was recognised that the transfer to the new care plan documentation "Had not gone to plan." But there was no clear action taken from this meeting to progress this further.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the accident and incident records we saw there was an incident in July 2015 which met the criteria for a safeguarding alert to be raised with the local authority and for a notification to be sent to the CQC. We discussed notifications with the home manager and advised them to work with the registered manager to ensure that all notifiable incidents were raised with the appropriate external agencies in future.

The service undertook a survey of people using the service, and this mostly had positive feedback and any actions arising had been carried forward and acted upon by the home manager.

The external healthcare professional we spoke with told us they found the staff and home manager approachable. The service contacted them appropriately and sought out advice. They told us that district nurses supported the service and worked effectively with the care and nursing staff.

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 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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission of any abuse or allegation of abuse in relation to a service user. Regulation 18 (Registration) (2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not carried out, collaboratively with the relevant person, an assessment of their needs and preferences for care and treatment of the service user. Regulation 9 (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not assessed the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (2)(a)(b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not ensured that systems and processes were established and operating effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured that processes were in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured that persons employed by the service provider in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)