Health and Home (Essex) Limited

Ravensmere Rest Home

Inspection report

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Essex
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Tel: 01702330347

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

What life is like for people using this service:

The overall rating for this service is 'Inadequate' and the service is therefore 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.

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.

People were at risk of harm as fire safety procedures and checks were not effective and the maintenance of fire doors did not keep people safe from the risks of fire.

People were at risk as the infection prevention and control systems were not effective and did not reflect best practice.

Staff members did not always follow safe practice when supporting people with their medicines.

People's individual preferences were not prompted when supporting them with meals and food options.

The physical environment did not contain appropriate signage to help people orientate themselves to their surroundings.

People's individual protected characteristics were not clearly identified.

People's privacy was not always respected.

People's individual communication needs had not been assessed in line with best practice.

The provider did not have effective systems in place to monitor the quality of the service they provided or to

drive improvements where needed.

People had care and support plans which gave staff members the information that they needed to provide care but staff members did not routinely read them.

People felt that the activities that were available were limited and that at times they felt unstimulated.

People did not always receive timely support when showing signs of anxiety or distressed.

Staff members had access to training and felt supported in their role. New staff members completed a structured introduction to their role.

People were referred to additional healthcare services when it was required.

The provider had systems in place to respond to complaints or compliments from people or visitors.

Rating at last inspection: Good (Last report published 17 September 2016). Following significant concerns regarding people's safety the current rating is 'inadequate' overall.

About the service:
Ravensmere Rest Home is registered to provide accommodation and personal care for up to a maximum of 24 people who have a diagnosed mental health condition or who may be living with dementia. Ravensmere does not provide nursing care. At this inspection 18 people were living there.

Why we inspected:
This was a planned inspection based on the rating at the last inspection, 'Good.'

Enforcement.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded

Follow up:
We will monitor Ravensmere Rest Home and re-inspect as part of our published inspection programme timetable. In addition, we will receive regular updates from the provider on the progress they are making in addressing the concerns we have raised with them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Ravensmere Rest Home

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
One inspector and one expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses care services. In this instance services for older people.

Service and service type
Ravensmere Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At this inspection 18 people were living there.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection took place on the 17 November 2018 and was unannounced.

What we did:
Before our inspection visit, the provider completed a Provider Information Return (PIR). We used this as part of our planning. The (PIR) is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

We asked the local authority and Healthwatch for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

During the inspection we spoke with four people, the registered manager, the director, three care staff workers and the cook. We reviewed a range of records. This included two people's care and medication records. We confirmed the safe recruitment of one staff member and reviewed records relating to the providers quality monitoring, health and safety, compliments and complaints.

Inadequate

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management, Systems and processes
• We saw fire doors, used to prevent the spread of smoke or fire, were poorly maintained and did not provide assurance that people would be safe in the event of emergency.
• We saw some fire doors had been wedged open which would have prevented them from closing in the event of an emergency.
• We saw fire doors with broken self-closures which prevented them from effectively closing in the event of a fire alarm activation.

Following this inspection site visit we contacted the fire and rescue service and shared our concerns with them.

• People were not safely supported by staff members. We saw one person walking around with the use of a mobility aid. The rubber feet of the mobility aid were coming off making it unstable. We raised our concern with a staff member who then corrected this. However, this person had been walking around for some time without any staff member or member of the management team recognising the risk to the person or taking action to rectify it.
• We saw one person sat in a wheelchair. There were no foot plates on the wheelchair. We saw a staff member start to move this person without ensuring their feet were off the floor. This person's foot started to bend backwards under the chair before they lifted their feet up. This was in sight of the registered manager and the director who did not correct the staff members practice.
• We saw a staff member stack three plastic garden chairs in the living area. One person then sat on these chairs which started to wobble putting the person at risk of tipping over. A staff member supported this person to put on their shoes whilst sat on these chairs further making them unstable as they now lifted one foot off the floor. The staff member who stacked the chairs and the staff member who then supported the person failed to identify the potential risk to the person who then sat on them.
• We saw a light fitting in one of the stairways did not contain a light bulb. This meant that people and staff members could access this area which was poorly lit and put them at risk of trips and falls. We asked the registered manager about this missing light bulb and how long it had been missing. They could not give us an indication of how long it had needed repair or replacement or even what the issue with the light was.

Preventing and controlling infection
• People were at risk of harm as the physical environment at Ravensmere Rest Home was, in places, in a poor state of repair.
• The baths at Ravensmere Rest Home had worn enamel exposing the surface beneath which prevented effective cleaning. The hoists used to support people into the bath were rusted with the surface below exposed.

• We saw a number of wheelchair foot plates stacked in a pile in the bathroom which all had extensive rust on them preventing effective cleaning.
• We saw ineffective water seals around bathroom fixtures which were worn, making them difficult to clean. The grout between tiles in the bathrooms was, in places, missing which prevented effective cleaning.
• There were no facilities for the safe storage and disposal of clinical waste at Ravensmere Rest Home. We saw one staff member placing clinical waste into a yellow bag which was stored in the resident's bath. This bathroom was in constant use by people who had open access to the used clinical waste stored there. We asked the registered manager who told us that there was nowhere else to put the waste.
• Staff members did not follow effective infection prevention and control practices when supporting people.
• We saw two staff members support one person to transfer from a wheelchair to a chair. They used a hoist with a sling. The hoist was rusted which made cleaning ineffective. We asked the staff members about the sling they had used for the person. They told us they had one sling that they used for four people and that people did not have individual slings. This put people at risk of contracting infectious illnesses.
• We saw one staff member had just supported someone with their personal care. They then supported this person into the lounge area whilst still wearing the gloves that they used during the personal care. They then passed the person a drink whilst still wearing the same gloves.

Following this inspection, we passed our concerns to patient safety at the clinical commissioning group for their awareness.

• We saw one staff member supporting people with their medicines in the communal living area. On one occasion we saw this staff member walk away from the medicine trolley without locking it. On another occasion we saw the same staff member had left the keys to the medicine trolley in the lock. The staff member did not follow safe practice when supporting people and therefore others were put at risk as they had unsupervised access to medicines. The staff member told us they had been assessed as safe and competent to support people with medicines. However, no one had identified or pointed out to them that they were not following unsafe practices. This included the director who passed the medicines trolley on both occasions without identifying or highlighting this poor practice.

Learning lessons when things go wrong
• The provider reviewed any incidents or accidents to see if any further action was needed and to minimise the risk of reoccurrence. However, when the provider and registered manager observed unsafe staff practice they did not challenge it or take action to correct it. Neither did they act to recognise and replace unsafe equipment and repairs to the physical environment at Ravensmere Rest Home.

Staffing levels
• People told us they were supported by enough staff to meet their needs promptly. However, we did see people that were left for prolonged periods of time in the communal areas without any staff interaction or conversation.
• One person told us about their night time experience at Ravensmere Rest Home. They said, "There are times when I'm a little frightened with one person screaming all the time, and some of the residents walk around all the time. I do get a bit frightened at night." This person told us they had not been asked by the management team about their experiences or how they could assist to make them feel safer when living at Ravensmere Rest Home.
• We asked people about the staff members response times when they used their call bells in their rooms. One person asked us, "Do I have a call bell in my room?" This indicated to us that they did not know about the call systems in their room. We saw the communal bathrooms, communal sitting areas and the outside space which people used for smoking did not have accessible call bell systems which people could use to request assistance. The provider did not have safe systems in place for people to request support in a timely

manner.

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

Using medicines safely
• The registered manager had systems in place to respond to any potential medicine errors. For example, at this inspection the registered manager identified that they had not received the correct amount of medicines from a dispensing pharmacy. They checked what they should have received and made contact with the pharmacist to correct the dispensing error.

Requires Improvement

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough with choice in a balanced diet
• We asked people about the food they received at Ravensmere Rest Home. One person said, "I like the food, but I hear some others telling the chef they don't like it." Another person told us, "The food is OK here – the chef is good. If they know there's something that you don't like they serve an alternative for you". However, we didn't see any discussion between staff or people about food options or choice. We did see one person had a sausage as an alternative to the chicken for lunch but there was no discussion about this or what they would prefer.

Adapting service, design, decoration to meet people's needs
• The physical environment at Ravensmere Rest Home did not meet people's individual needs. At the time of this inspection a number of those residing there were living with dementia. Ravensmere Rest Home did not provide suitable signage for people to orientate themselves to their surroundings. Walls floors and doors to bedrooms, bathrooms and toilets were not distinctive. There was no personalisation of people's individual bedroom doors to assist in their orientation or mobility. We asked staff members and the registered manager about this. One staff member we spoke with did not understand what we were asking in terms of a 'dementia friendly' home for people to live in. The registered manager said, "I have mentioned this a number of times to the provider and I know what is needed but nothing seems to happen." We asked the director about this. They told us, "We are planning some redecoration and we will consider this as part of the colour schemes." However, at this inspection neither the registered manager or director had a clear plan to make the physical environment at Ravensmere Rest Home more suitable to those who lived there.

Staff skills, knowledge and experience
• New staff members completed a structured introduction to their role. This included completion of induction training, for example, basic food hygiene and fire awareness. In addition to this, they worked alongside experienced staff members until they felt confident to support people safely and effectively. However, despite the management team telling us that all staff members were trained in fire awareness and fire prevention no one had acted to correct the fire safety concerns we raised at this inspection. In addition, staff members told us that they had been trained in infection prevention and control. Yet we saw staff members routinely follow poor practice when supporting people.
• We asked one staff member about the dementia care course they had attended. We asked how this changed how they worked with people. Unfortunately, the staff member expressed to us that they did not understand the question owing to difficulties understanding English as a language. Despite several attempts to rephrase this the staff member was still unable to outline the benefit of their training on those they supported. This has a potential impact on those receiving care and support as they may experience difficulty

making their needs know to those assisting them.
• The registered manager and the provider did not have systems in place to assess the competency of staff members or their understanding of people's needs or how they were meeting them.
• The registered manager and director told us staff members new to care were supported to complete the care certificate. The care certificate is a nationally recognised qualification in social care. However, none of the care staff we spoke with understood what the care certificate was.

Staff providing consistent, effective, timely care
• Staff members passed information between themselves as part of structed handovers at the end of one shift and the start of the next. This information contained details about the person and the support they had received and any medical or personal issues which still needed to be considered.
• However, staff members we spoke with told us that they did not read the care and support plans that had been written to direct their work. One staff member told us that English was not their first language and that the provider was supporting them to complete training to improve their communication skills. However, the lack of awareness and the practice of not reading the care and support plans put people at the risk of receiving inconsistent care and support.
• People had access to healthcare services when they needed it. This included foot health, GP, district nurses and opticians. The provider referred people for healthcare assessment promptly if required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed and regularly reviewed. People's physical, mental health and social needs had been holistically assessed and recorded in line with best practice.
• However, people's protected characteristics under the Equalities Act 2010, like faith and disability, were not effectively identified as part of their needs assessments. Staff members we spoke with could not tell us about people's individual characteristics or how they and the management team were acting to promote people's protected characteristics.

Ensuring consent to care and treatment in line with law and guidance
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.
• In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The provider had made appropriate applications and had systems in place to renew and meet any recommendations of authorised applications.

Requires Improvement

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

RI: People did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• The overall valuing of people as individuals was compromised by the providers inaction to identify or address aspects of the physical environment within which they lived. For example, people were expected to use a toilet where used incontinence pads were stored in their bath. This did not demonstrate that the provider had embedded a valuing and dignified approach to the care they provided.
• People were not always supported in a way that maintained their privacy or promoted their dignity. For example, we saw people's bedroom doors had a large glass window in them. Albeit, many had coverings over the window we saw one persons didn't. Anyone passing this person's room could see what was happening in there.
• We saw people sat in the lounge area without appropriate footwear on. One person moved from the lounge to outside and back several times with only one shoe on. Their other foot appeared to be reddening from the cold. Eventually a staff member saw that a shoe was missing and then replaced it. However, this was done without any communication with the person or informing them what was happening.
• When people were able to they were supported to maintain their independence. One person said, "I'm quite independent here. I have a wash in the morning which is my choice and I do it all myself. I don't need help."

Ensuring people are well treated and supported
• People were not always treated in a respectful and valuing way by those supporting them.
• One person told us, "I used to go to church but I can't get there now. I do love the hymns and singing, which I miss a lot." The provider did not have effective systems in place to identify and support people's protected characteristics from potential discrimination. Protected characteristics are the nine groups protected under the Equality Act 2010. They include, age, disability, gender reassignment, marriage and civil partnership, religion etc. The care and support plans we saw did not clearly identify people's individual characteristic nor did they detail what the management team were doing to promote such aspects of people's lives. Staff members we spoke with could not tell us about people's cultural background or not how they supported them to maintain their own personal identities.
• People were not always supported in a timely or consistent manner when they showed signs of anxiety or distress. For example, one person was shouting and crying in the lounge area. A staff member shouted to them from across the lounge, "What's up [person's name]." There was no attempt to contact this person or to directly engage with them. This was in the presence of the registered manager and the director and neither acted to correct the staff members practice or to offer support to this person. However, on other occasions we did see staff members offer appropriate physical touch and spoke with this person in a way that appeared to ease their distress.
• People spoke about the staff who supported them in positive terms. We did see some kind and positive

interactions between staff members and those they supported. One person told us about one particular staff member. They said, "They are very good, very kind and helpful. They are my friend."

Supporting people to express their views and be involved in making decisions about their care
• People were not consulted about menu choices or encouraged to identify what they would like for lunch. The food available to people was not based on the personal preferences of people living at Ravensmere Rest Home but on the availability of ingredients. For example, on the day of our inspection site visit the menu indicated that pork was for lunch. However, this dish had been changed to chicken thighs. We asked a staff member about this and they told us that the lunch had been changed as the chicken was approaching its use by date and needed to be used. They went on to tell us that this was common practice. People's food options and menu choices were directed by the available food and not their personal likes and dislikes. This limited people's ability to make individual choices when it came to their diet. However, we did see one person received a sausage instead of chicken.
• People were not given options on where they would like to sit when entering the dining room or lounge. We saw people's likes and dislikes had been recorded in their care and support plans however, the staff we spoke with told us that they didn't read them. We did not see evidence that people were routinely involved in making decisions about their day to day care and support.
• We saw information which was confidential to the person was kept securely and only accessed by those with authority to do so.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

RI: People's needs were not always met.

Personalised care
• People did not always receive information in a way they found accessible. At this inspection Ravensmere Rest Home was providing support for those experiencing hearing loss, sight loss and those living with dementia. The management team had not effectively implemented the Accessible Information Standards. From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.
• People told us they would like to be involved in more activities as there was little to occupy them during the day. Throughout this inspection we did not see anyone engaged in any organised activity other than watching tv or reading a newspaper. The physical setup of the lounge area was not conducive to meeting people's needs for stimulation. For example, the TV was on but also music was playing. This was confusing for people. We saw one person ask a staff member where the music was coming from. This staff member did not respond to them or make efforts to highlight why the music and tv were on at the same time. In addition, people were sat beneath the TV and with their backs to it so that they couldn't watch it even if they wished to. We asked the registered manager about activities for people. They told us that care staff usually supported people with activities but they hadn't that morning. They could not provide an explanation why not. They went on to say that sometimes they had external people coming in to do activities with people. However, we did not see a programme of activities for people to make decisions about what they wished to engage with. One person told us, "I like the person who comes in around once a month and we do a bit of keep fit. It's good fun and we have a laugh."

Improving care quality in response to complaints or concerns
• The provider had systems in place to record, investigate and to respond to any complaints raised with them.

End of life care and support
• At this inspection no one was receiving and of life care at Ravensmere Rest Home.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Leadership and management
• We identified significant shortfalls in the quality of leadership and management which impacted on people using the service.
• The quality checks completed by the management team and the provider were ineffective in identifying improvements needed in the service that people received. For example, the provider failed to act to identify and correct significant shortfalls in their fire prevention systems which put people at risk of harm.
• The management team and the provider failed to undertake effective quality checks of the infection prevention and control systems in place at Ravensmere Rest home. For example, we saw two partly completed checks of the environment. Both checks, one completed in January 2018 and one in November 2018 were incomplete. Neither the registered manager nor the provider oversaw these checks or acted to rectify deficits identified. For example, both checks highlighted that there was no sanitising hand rub available for people, staff or visitors located within the premises. This put people at risk of harm from communicable illnesses. At this inspection we saw that this sanitising hand rub was still not available. In addition, it had been reported to the provider and management team that certain protective equipment should be available for staff members. At this inspection we saw this equipment was still not provided putting staff members at risk of harm.
• Maintenance issues reported to the management team, and the provider, were not addressed in a timely manner, putting people at the risk of harm. For example, the light bulb in the stairway was missing and no one at Ravensmere Rest Home could tell us when this lighting was first identified as faulty.
• The provider's quality monitoring was not effective in identifying the concerns that we found at this inspection. The provider did have a plan of action regarding some redecoration within the building but this had not highlighted the fire safety concerns or the infection prevention and control concerns. Neither did it include consideration to making the environment 'dementia friendly' despite the director telling us they were dementia specialists.
• We highlighted to the director our concerns regarding the poor and unhygienic condition of people's over chair tables and they then made efforts to order some new ones on the day of our inspection. However, the director had failed to act prior to us identifying them as a concern for people's safety.
• We asked a member of the management team about the concerns with the environment within which people lived. They said they were glad that we had picked up on this as it may help to make the changes they thought was needed. They went on to tell us that the provider was slow in acting when repairs and renewals of equipment was raised with them.

Continuous learning and improving care
• The registered manager told us they kept themselves up to date with developments and best practice in

health and social care to ensure people received positive outcomes. However, they were not aware of the changes to law regarding the implementation of the accessible information standards and therefore these were not effectively implemented at Ravensmere Rest Home. In addition, they did not adhere to best practice with regards to infection prevention and control and they failed to ensure action was taken to make the physical environment safe for people to live in.
• The registered manager did not have effective systems in place regarding the failure to address when things went wrong. For example, they did not have a means to escalate concerns regarding the unsafe maintenance of the location to the providers to resolve the issues we have highlighted as part of our inspection.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong
• Staff members we spoke with told us they had raised issues regarding the physical environment within which people lived with the provider. However, they went on to say that nothing ever happened as a result and therefore stopped making suggestions or reporting concerns.
• The provider did not have effective systems in place to promote high quality care and support. The provider failed to assess the quality of people's experiences including meal times and activities. The director and registered manager failed to correct unsafe staff practice and behaviour. The provider failed to act when issues had been raised with them to make the property more suited to those that lived their including making the establishment more 'dementia friendly'.
• We spoke with staff members about policies and procedures which impacted on their daily work including the whistle-blowing policy. However, those we spoke with did not feel they would be listened to by the provider if they did highlight concerns. All those we spoke with told us they knew who to report issues to outside of the organisation including the local authority and the police.

Engaging and involving people using the service, the public and staff
• The provider did not have effective systems for gathering people's views of the service that they received. Although the provider had completed some visits these were not effective in identifying the issues we found at this inspection. They had not developed an action plan to and there was no available information to people and visitors regarding any feedback that they had received or changes they planned to make.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements
• A registered manager was in post and was present throughout this inspection. They understood the requirements of registration with the Care Quality Commission including informing us of significant events. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. These include authorised deprivation of liberty safeguards referrals. However, they failed to recognise and act on environmental issues which put people at risk of harm.

These issues constitute a breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We saw the last rated inspection was displayed in accordance with the law.

Working in partnership with others
• The management team had established and maintained good links with the local community and with other healthcare professionals which people benefited from.

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 17 HSCA RA Regulations 2014 Good governance The providers quality monitoring systems were not effective in identifying and providing good care.