Titleworth Limited

Coombe Hill and Blenheim Lodge 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**

Overall summary

This inspection took place on 23 September 2015 and was unannounced. At the last inspection on 19 August 2014 we found the provider was meeting the regulations we checked.

Coombe Hill and Blenheim Lodge is a nursing home for up to 44 adults. At the time of the inspection there were 40 people living across the three floors that make up the home. The service provided nursing care to older and younger people, people with physical disabilities and those with acquired brain injuries.

There was no registered manager in post, although the manager had begun the process to register with Care

Summary of findings

Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The service had not reported all allegations of abuse to the local authority safeguarding team as part of their responsibility to keep people safe. The local authority plays the lead role in investigating allegations of abuse. This meant the service did not always operate effective procedures to keep people safe.

Risks assessments and care plans were not always reviewed regularly, even when risks to people were high and when people's needs had changed. This meant care plans were not always reliable for staff to follow in supporting people. In addition, the provider did not always manage risks to people appropriately and ensure staff followed current plans in place. For example by following guidance in place relating to how often people should be repositioned to reduce the risks of pressure ulcers. People did not always have care plans in place to meet all their individual needs such as needs in relation to alcohol addiction and blindness.

The provider did not always monitor the risks of malnutrition to people appropriately and did not always take robust action when people lost a significant amount of weight. The consistency of food to be provided to people at risk of choking was not always clear in their care plans which meant they may not have received nutrition in a safe way. However, people received a choice of meals and liked the food provided.

Although people were confident complaints would be investigated and responded to appropriately, information about complaints, how they had been handled and the outcomes were not always recorded. This meant there was not a clear audit trail showing how effectively systems for managing complaints were operating in the home.

Staff had not received training and supervision regularly in order to be supported appropriately in meeting people's needs. There were enough staff deployed to meet people's needs and staff were recruited safely.

Although a range of audits were in place they had not always identified and rectified the issues we found during our inspection.

The manager monitored accidents and incidents in the home to check people received the right support. The premises and equipment were safe and well maintained with a range of regular health and safety checks carried out.

People received support to access healthcare services such as the GP, dentist and optician.

Procedures to manage medicines were robust and staff managed people's medicines safely.

The service was meeting their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

Staff were caring and treated people with dignity and respect. People were involved in planning their care and care was delivered as people wished. People's end of life wishes were gathered and recorded and staff received training in supporting people nearing the end of their lives.

An activity programme was in place, led by an activities officer and people were offered a range of activities and outings they were interested in. People were supported to meet their spiritual and religious needs.

The service communicated well with people using the service, relatives and staff. Whistleblowers were supported to raise issues anonymously if they wished so any concerns could be addressed appropriately.

We found a numbers of breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not always safe.

Allegations of abuse were not always reported to the local authority safeguarding team as required and appropriate protection plans the home put in place may not have been appropriate. Risks to people were not always reviewed regularly with the right action taken to reduce the risks.

There were enough staff to meet people's needs and staff were recruited safely. The premises and equipment were managed safely. Staff managed people's medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not always monitor the risks of malnutrition and dehydration to people effectively. However, people received a choice of food and were positive about the food they received. Staff had not received regular supervision and there were gaps in staff training which meant they were not fully supported to fulfil their roles and responsibilities.

Staff supported people to meet health needs.

The provider was meeting the requirements under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and the service took the right action to support people who required DoLS as part of keeping them safe.

Is the service caring?

Good

The service was caring.

Staff were kind and knew the people they were working with, including their backgrounds and preferences. Staff treated people with dignity and respect and people were involved in planning their care. Visitors were encouraged to visit. Systems were in place to support people appropriately at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints were not always recorded clearly to provide an audit trail showing the elements of the complaint, action taken to resolve it and the outcomes for people. People did not always have care plans in place regarding specific needs for staff to follow such as alcohol addiction and blindness.

People were provided with a range of activities they were interested in. People's religious and spiritual needs were met.

Summary of findings

Is the service well-led?

The service was not always well-led.

Although a range of audits were in place to assess, monitor and improve the service, they were not effective because they had not identified and rectified the issues we found during our inspection.

A new manager was in post who had begun the process to register with CQC and we received positive feedback about them. Leadership was visible through the home and effective systems were in place for communicating with people using the service, staff and relatives.

Requires Improvement 

Coombe Hill and Blenheim Lodge 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 September 2015 and was unannounced. It was undertaken by an inspector, a pharmacist inspector, a specialist advisor (a registered nurse) 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 service.

Before our inspection we reviewed information we held about the service and the provider. We also contacted the local authority and a nurse from the 'impact team' which had recently been supporting the service to ask them about their views of the service provided to people.

During the inspection we observed how staff interacted with the people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people using the service and three relatives, the manager, deputy manager, the clinical lead, maintenance operative, activities officer, chef, three care workers and two nurses. We looked at five people's care records and 18 people's medicines records, five staff recruitment files and records relating to the management of the service, including quality audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel safe here." Staff were aware of the signs people may be being abused and how to report this to keep them safe. The service had referred some allegations of abuse to the local authority safeguarding team for investigation as required. However, there had been two allegations of financial abuse which had not been reported to the local authority safeguarding team as required under the pan-London multi-agency safeguarding adult's policy and had not been reported to CQC as required by law. The manager had reported the incidents of financial abuse to the police and taken some actions to prevent these incidents happening in the future. However, because the safeguarding team had not been involved we could not be sure the actions taken to reduce the risks of this happening again were sufficient. The manager told us not reporting these to the local authority safeguarding team was an oversight and they will ensure such reporting is done in future.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk management plans were in place for staff to follow in supporting people in relation to risks, such as for moving and handling and pressure ulcers. However, risk assessments and care plans were not always reviewed regularly to ensure they remained current and reliable in guiding staff to care for people safely. For example, a person's risk assessment for choking had not been reviewed since July 2015, even though there had been a change to the way they received their nutrition. The risk assessment for a person at very high risk of developing pressure ulcers had not been reviewed since July 2015. This meant the risks were not being closely monitored by the service so that the service could be sure they were taking all actions necessary to reduce the risks of developing pressure ulcers.

Staff were not always taking the necessary action to reduce the risks to people. We checked pressure relieving equipment and saw they were appropriate for people's needs, with air mattresses set to the right settings for pressure relief, according to people's weights. However, records showed people were not always repositioned as often as their care plans said they should be to reduce the risks of developing pressure ulcers. For example one person's care plan said they should be supported to reposition every three hours, yet we found sometimes they were supported every five hours. In addition, turning charts had no reference to how often people should be supported to change position for staff to refer to.

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

Where allegations of abuse were substantiated, the provider worked with the local authority to reduce the risks of a recurrence. For example where a recent allegation of neglect was substantiated the provider put plans in place to reduce the risks of similar incidents happening again.

We found staffing levels in the home to be sufficient to meet people's needs. Staff responded promptly when people rang their call bells for assistance. Many staff had worked at the home for several years and other staff had been newly recruited after a recent recruitment campaign and some agency staff were used where necessary. We checked rotas and saw the number of staff on shift was the same as the provider had identified as required. Staff were visible in all parts of the home and did not appear hurried and were able to interact appropriately and provide people with the support they required.

The provider operated safe recruitment procedures to ensure only suitable staff worked with people living in the home. The provider ensured a full employment history was taken for each applicant and they explored any gaps. They checked nurses' PINs prior to them working in the home. Applicants all had a criminal records check carried out before they were able to work unsupervised with people. Suitable references were taken as well as evidence of right to work in the UK and consideration was given to any health conditions, which would affect their ability to carry out their role, and how the service could make reasonable adjustments to support them. Not all staff files contained suitable identification and proof of address. However, the manager told us these documents were always viewed as part of obtaining a criminal records check, but may have been stored in error. They told us they would review staff files to ensure this information was stored appropriately, as required by law.

A programme of renovation was in place across the home. The manager told us this included replacing the carpets in the communal areas in the next few weeks, which we saw

Requires Improvement

Is the service safe?

were threadbare in places and a possible slip hazard, and repainting the walls which we saw were chipped and stained in places. The kitchen area was also due to be upgraded as part of this programme.

The premises and equipment were well maintained with checks carried out by a maintenance team and some external contractors. Records showed a programme of checks on the environment, electrical and fire systems, hoists and slings, pressure relieving equipment and bed rails. The water system was monitored regularly to check temperatures were suitable to prevent people being scalded and that mechanisms to reduce the risk of Legionella infections were effective. Legionella is a bacterium which can accumulate rapidly in hot water systems if control mechanisms are not in place. Window restrictors were in place across the home to reduce the risks of people falling from height. The fire authority had recently determined the service was not meeting regulations relating to fire safety. However, the service had an action plan in place to improve and was within the timescales set for improving by the fire authority.

Accidents and incidents were recorded with clear information relating to what had occurred. The manager checked each accident and incident form to see that people received the necessary support and put in place actions to reduce the risks of repeat occurrences. The manager also analysed accidents and incidents to look for patterns to identify if there were systemic problems within the service, which could then be addressed through looking at factors such as the environment and staff training.

The provider had arrangements so that the risks associated with medicines were reduced. We checked medicines stocks and confirmed medicines had been given to people as indicated on Medicines Administration Records (MAR). There were accurate records of medicines administered to people as well as medicines received and disposed of, providing a clear audit trail. Medicines were stored securely. People's allergy status was recorded which allowed staff to identify medicines that should not be prescribed to them keeping them safe. Individual protocols were in place for medicines to be administered as required so nurses knew how much, how often and in what circumstances each medicine should be given. Medicines which were prescribed for mood, pain or to treat seizures were recorded on handover notes, as well as on the usual MAR, to increase staff awareness that administration had occurred so they should monitor people more closely than usual to support them. A suitable procedure was in place for when people left the home for short periods with their medicines, with checks carried out and records made. Where a person was fed through a tube in their stomach (PEG) there was an individual protocol in place for staff to follow which was regularly reviewed by a dietician. Staff received annual training in medicines administration to support them in keeping their understanding of their responsibilities in relation to medicines current.

Many of the people who lived in the home required medicines to help their pain. In the care plans we looked at we saw risk assessments for managing pain and pain charts to assess how much pain the person was in. In one person's records we observed that assessments were every four hours and staff recorded the level of pain the person was in and how much pain relief the person needed, administering what was required.

Requires Improvement

Is the service effective?

Our findings

The provider did not always monitor the risks of malnutrition to people well. For example, a person who had previously been assessed at high risk of malnutrition had not had their malnutrition risk assessment reviewed for three months between April and July 2015. In addition when a person lost 1.8 kg between July and August 2015, having gradually lost weight over previous months, the provider had supported them to see their GP who had prescribed nutritional supplements. However, the weight loss had continued after this and the service had not provided the person with further support. They did not have a specific care plan in place regarding how staff should manage their weight loss and support them appropriately.

Where people had been identified as being at risk of dehydration or malnutrition staff did not always monitor their food and fluid intake properly using the monitoring charts provided. This meant the service could not be sure people were receiving the necessary food and drink to stay nourished and hydrated.

Staff supported some people appropriately with their meals to prevent choking while others were not always supported appropriately. When a person was at risk of choking staff were aware of this and followed guidance from a speech and language therapist in supporting them. They assisted them to sit at the right angle to reduce the risk, helping them to eat at their own pace. However, for some people it was not clear how their food should be prepared to support them safely to eat as their care plans stated a 'soft/pureed diet' should be provided. Soft and pureed diets require food to be prepared differently and are required for different health needs. Because clear information was not always available to staff on the consistency of foods, people were at risks of receiving food that might not be suitable for them and that could cause harm to them.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The chef also understood people's dietary needs and provided the right food for them, such as for diabetes and lactose intolerance.

Staff had not always received regular supervision and so the manager had changed systems to rectify this. Not all staff had received an annual appraisal. The manager was rolling out a system for staff to receive supervision every two months since they had started. The manager was aware of this and was also reviewing systems to rectify this so that staff received appropriate support and feedback.

Training records showed the manager had identified some gaps in staff training requirements which meant their knowledge may not be current. For example many staff had not received training in the last few years in first aid, MCA and DoLS. The organisation had put in place a training programme and various training courses were arranged for staff to address this. However, this did not include training for staff to meet people's specific needs such as Huntington's disease, multiple sclerosis, dementia awareness and challenging behaviour. The manager told us they would review the training programme in light of our feedback.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People made positive comments about the food and drink they received. One person told us, "The food's not bad, I can choose what I want". Another person said, "The food is ok". People had a choice of food and drink and were provided with snacks during the day. Staff also knew people's food and drink preferences. We observed a mealtime and saw people received the right support with eating and drinking with staff on hand to support people, including those who ate in their rooms.

Staff received some training on a regular basis, such as annual moving and handling and medicines management. The manager was rolling out the new Care Certificate for all staff as part of filling in staff training gaps. The Care Certificate is a national induction programme designed to give all new care workers the same knowledge, skills and behaviours when they begin their roles. It covers the basic range of topics all care workers should know as part of their role and so the service saw this as being useful for all staff, not just new starters.

The service was meeting the requirements under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) aim to protect people who lack mental capacity, but

Requires Improvement

Is the service effective?

who need to be deprived of liberty so they can be given care and treatment safely in a hospital or care home. Staff understood their obligations in relation to the Act, such as when to carry out assessments of people's capacity to make decisions and to ensure decisions were made in people's best interests when they lacked capacity. For example, when people received their medicines covertly, records showed an assessment of their mental capacity in relation to this had been carried out and the decision had been made in their best interests, through discussions with their family and GP, in accordance with the MCA. The service had applied for DoLS for several people and had notified CQC of the applications and outcomes as required by law.

People received support with their health needs and the service liaised well with health professionals as part of this. One person told us, "I can see a doctor and a dentist when I need to". People's care plans contained information about their health needs as well as the support they had received from health professionals such as GPs and dieticians. Records showed people's medicines were regularly reviewed by their GPs and other health professionals and nurses explained how they frequently requested these reviews and blood tests to monitor side effects of some medicines. The care plan of one person showed how the staff supported them and worked collaboratively with staff from a hospital to prepare them for a medical procedure and to help ensure a safe outcome.

Good

Is the service caring?

Our findings

People and their relatives made positive comments about the staff. One person said, “The staff are good, they always do their best.” A relative said, “Everyone is very friendly and very nice and there seem to be more nurses here now than a year ago.” A second relative said, “The staff are all kind and approachable and very caring.” During our inspection we also observed staff interacted with people with warmth and affection and supported people in a caring manner.

People told us staff always respected their privacy and dignity. They described how staff were always careful to ensure doors and curtains were shut before they provided personal care. Our findings were in agreement with this. We observed that when staff came to reposition a person in a shared room they positioned a screen so that others in the room could not see what was taking place and they checked the curtains were drawn. Staff spoke about people in a respectful way during our conversations with them and we saw they were careful not to talk about people’s personal information where others could overhear. Information about people was kept locked away to maintain confidentiality.

Staff supported people to maintain their personal appearance. A hairdresser visited regularly and we saw people who required support were wearing clean, pressed clothes.

Staff had a good understanding of people’s likes, dislikes and backgrounds. When we asked a person whether staff knew them they said, “Yes.” The manager and staff were able to tell us about people without reference to any files. One relative told us how staff knew their family member well. They said, “[Staff] are very good at giving advice to buy suitable clothes for [my family member]. Her clothes have to be nice but also suit her difficulties . . .they suggest the best type for me to buy.”

The service encouraged visitors, and people and their relatives told us they could visit without restriction. We observed many relatives and friends visiting throughout our inspection and saw they were able to meet privately.

People’s preferences and choices for their end of life care were clearly recorded in their care plans. In addition the service had close links with the local hospice that provided advice and support to staff. Staff received training on end of life care to understand how to provide care to people reaching the end of their lives. The service had equipment to meet people’s end of life care needs such as syringe drivers and staff had received training on using this equipment. Syringe drivers are sometimes used to administer pain relieving medicines when people come towards the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they knew how to complain and were confident the service would investigate and respond to their complaints appropriately. One person told us how the management had responded well when they raised an issue about a lost item and were going to replace the item for them. However, the service did not keep clear records of complaints, only of the numbers of complaints received each month and the category they fell into. There were no clear records detailing the nature of the complaint, how the provider had responded to the complaints, the outcome of their investigation, whether people were satisfied with the outcome and lessons learnt. When we raised our concerns with the manager that the complaints handling process was defective and did not meet regulations they told us they would review and improve the system immediately.

These issues were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people did not have care plans in place about their specific needs such as blindness and alcohol addiction for staff to follow in supporting them appropriately. However, the care plans in place were clear and individualised, being tailored to guiding staff in supporting people with their individual needs. We saw that people's health care and support needs were assessed before they moved into the home and this information was used to form their care plans. Care plans generally contained appropriate information about people's medical and physical needs and details such as the equipment they needed to ensure safe moving and handling. A few people in the home had epileptic seizures. There were care plans in place that described how to manage their care and treatment.. These people also had charts to record when a seizure happened so that their consultant could review how effective their treatment was. Personal hygiene care plans included information on grooming, oral hygiene and make up. In this way care plans were reliable for staff to follow in supporting people in the best ways for them.

The service supported people to engage in a range of activities they were interested in. One person told us, "I have been out to the theatre three times and also on a river boat trip." Another person said, "I've got my knitting, that keeps me occupied". During our inspection two people were supported to go into central London for a day trip by the activities officer. One person told us they were very much looking forward to seeing the places where they grew up. Other activities included the cinema, theatre and seaside trips were also provided. Activities provided in-house included a weekly film night, seated exercises and balloon games, arts and crafts, quizzes, hand massages and nail care. Cooking classes and a wine tasting event had also been provided in combination with a local supermarket. An easy listening singer visited regularly to entertain people in the home. In addition people's birthdays were celebrated with cakes and a present from the service.

People were supported to meet their spiritual and religious needs. Some people went to local places of worship such as churches and a Buddhist temple and church members visited the home fortnightly.

People received care according to their preferences and choices and they were involved in planning their care. People and their relatives were encouraged to complete 'My life story' booklets which detailed their life stories, preferences, interests and what was important to them and staff were aware of this information so they could take this into account when providing care to people.

People and their relatives were involved in making decisions about their care as much as they wanted and were able to. The service arranged review meetings with people, their relative and keyworker every few months. In this meeting they checked people were satisfied with their care and whether there were any changes they would like to be made.

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of audits in place to assess, monitor and improve the quality of the service. However, these audits had not identified the issues we found in relation to assessing and managing risks to people, safeguarding, meeting people's nutritional needs and complaints recording.

People's care plans, staff knowledge and the care people received in relation to wounds such as pressure ulcers was good generally. However, records demonstrating that people were receiving the right care in relation to their wounds were not always in place. Pressure ulcers for two people had recently healed. However, records did not reflect staff had evaluated and documented the people's wounds each time they were dressed using tracings or photographs as recommended by the National Institute For Health and Care Excellence in their guidance (NICE, 2014) to monitor whether the wounds were healing. Records were also not updated to show when wounds had healed. This meant that people were not protected against the risks of inappropriate care and treatment that can arise if appropriate records are not maintained about their care and treatment.

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

A consultant audited the home every few months to identify concerns or possible breaches of regulations. We saw the home had put action plans in place to rectify issues raised at the most recent audit, including ordering more seating in the communal lounges for people and making improvements to care documentation. The management team carried out monthly audits of medicines and when medicines errors happened there was evidence of action taken to reduce the risks of them happening again. A relatives' satisfaction survey had recently been carried out and the provider was collating the results to identify areas of strengths and areas for improvement.

A new manager had been in post around six months and they had begun the process to register with CQC. People, their relatives and staff spoke positively of the manager. One staff member said, "The new manager is spot on [with everything], she's very good and kind". Staff told us they felt well supported by the manager, that she listened, took issues they raised seriously and she fed back areas for improvement in a constructive way.

Leadership was visible at all levels within the home. The manager was supported by a deputy manager who we observed supporting staff through the home. A clinical lead was also in post to improve clinical practice. The shifts were well organised and led by the person in charge, with a written plan for each shift which also identified tasks allocated to individual staff. Our observations and discussions with staff showed they were clear of their roles and responsibilities and what was expected of them during their shift.

Systems were in place to enable whistleblowing. A whistleblower is a person who raises a concern about a wrongdoing in their workplace or within the NHS or social care setting. The provider had a system in place where staff could raise any concerns through a dedicated phone line and e-mail address, while remaining anonymous if they wished. Staff were aware of this system and told us they would feel comfortable using it if necessary.

There were effective systems for communication within the home. At staff handovers detailed information about the events on the ending shift were discussed and this was clearly recorded. Regular meetings were held for the nursing staff, all staff, people using the service and also relatives. One person told us, "I attend now and again." People using the service, relatives and staff were involved in the running of the home through sharing their ideas and experiences at these meetings which were acted upon. However, records were not always available for all these meetings. The manager told us they would put systems in place to improve this issue immediately.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure care and treatment was provided in a safe way to people by assessing the risks to the health and safety of people receiving care or treatment and doing all that is reasonably practicable to mitigate such risks.** Regulation 12(1)(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 provider has not established and did not operate effective systems and processes to protect people from the risks of abuse and improper treatment.** Regulation 13(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider did not have suitable arrangements to meet the nutritional needs of people.** Regulation 14(1)(2)(a)(i)(b)(3)(a)(b)(4)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

The registered person has not established and did not operate an effective and accessible system for recording complaints by people in relation to the service provided.

Regulation 16(2)

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 did not ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service. Regulation 17(a)(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 did not ensure care workers received appropriate training to enable them to carry out their roles and responsibilities effectively. Regulation 18(2)(a)