Kettlewell House Limited

Kettlewell House 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 and 15 January 2016 and was unannounced. Kettlewell House Nursing Home provides accommodation, personal and nursing care for up to 29 people who are older or who have dementia, with or without nursing needs. There were 28 people living at the home at the time of our inspection. The service also provides a domiciliary care service to 10 people living in care suites available on site. These care suites include four flats in the grounds where more independent people live. They were able to access the care home in the same way as those living in the care home. We have combined this aspect of the service with the care home in this report.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe living at the home. People said: "Yes I do feel safe living here" and "its home from home". However, we found areas where the provider needed to make improvements.
Staff and the registered manager had a basic understanding of safeguarding people, but the registered manager did not always make referrals to the local authority safeguarding team when they should have done.

Risk assessment and management activities were not as detailed as they should have been. Some risk assessments had been incorrectly completed, and appropriate risk management plans were not always in place. Although incidents and accidents were recorded, they were not always well analysed to see if there was any link between them, and what action needed to be taken to stop the incident from happening again. Risks to the environment and routine maintenance were all well managed.

Recruitment practices were not robust. The provider did not ensure they completed all of the pre-employment checks for staff and volunteers before they began work. Staff were not well supported with training, supervision and appraisals. Most of the training was via e-learning and was not always effective. People told us there were enough staff on duty to meet there needs and that staff were helpful and kind.

Management of people's medicines was not always safe. Some records did not include a photograph of the person, and referrals to people's GP was not always made when it should have been. Medicines were handled and stored safely.

People told us they were well looked after, and staff were kind and caring. The registered manager had a very detailed understanding of people using the service and supported staff to meet people's needs. Staff tried to relieve people's distress in a caring way, but the provider did not give enough support to staff to enable them to meet the more specific needs of people with dementia. People's care plans contained basic information about people's needs and preferences but it was not clear how often they were updated.

Complaints were investigated but the outcome of investigations were not recorded. There was no evidence of learning from the outcome of complaints or incidents and accidents. Feedback from people was asked for by the provider, but they did not always act when areas of improvement were identified. Staff were given little opportunity to provide feedback in a formal way.

The registered manager had not notified CQC of some incidents as they are required to by law. Quality monitoring was understood by the manager and provider but it was not always completed effectively. Although action had been taken to address some issues raised, the registered manager did not have an action plan in place to ensure continuing quality improvement. Feedback about the manager and staff was positive from all of the people we spoke with.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, people were not properly protected from the risk of abuse, treatment was not provided with the consent of the relevant person, appropriate risk assessments and management plans were not detailed enough, and staff did not receive appropriate training, supervision and appraisal, and pre-employment checks were not fully completed. You can see what action we told the provider to take at the back of the full version of the report.

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. People were not always protected from the risk of abuse and avoidable harm. Incidents and accidents were not always well analysed.

There were enough staff on duty but recruitment checks were not fully completed for all staff, including volunteers.

Risk assessment and risk management plans were not detailed enough. Medicines were not always managed safely. Maintenance and environmental risks were well managed.

Is the service effective?

Requires Improvement

The registered manager and staff had a limited understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). Not all of the appropriate DoLs referrals had been made to the relevant authorities.

Training for staff was not effective and people with dementia did not have their needs fully met. Supervision and appraisal had not been regularly completed.

People were supported to have enough to eat and to maintain a balanced diet. Food was healthy and nutritious. However, availability of drinks was inconsistent at times.

Is the service caring?

Requires Improvement

The service was mostly caring. People's choices and preferences were understood and but they were not always well supported to express their views or make decisions about their care.

People's privacy and dignity was protected. Staff were kind, caring and compassionate.

Is the service responsive?

Requires Improvement

The service was not always responsive. Although people were asked for their feedback about the service this was not always acted on. Complaints were investigated, but the registered manager did not follow the provider's policy when responding to

complaints. Records were not made of the outcome of complaints.

Not everybody had their care plans regularly updated.

Is the service well-led?

Requires Improvement

The service was not always well led. While there were systems in place to monitor quality, they were not always used effectively. Notifications were not sent to CQC when they should have been.

People, relatives and staff gave positive feedback about the managers and said they were approachable. Staff all said they felt well supported.

Kettlewell House 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 and in response to information of concern we had received. 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 14 and 15 January 2016 August 2015 and was unannounced. The inspection team consisted of one inspector, a specialist nursing advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we looked at and reviewed all the current information we held about the service. This included notifications we had received. Notifications are events that the provider is required by law to inform us of. We also looked at information we hold about the service including previous reports, safeguarding notifications and investigations, and other information that was shared with us. We spoke with the local authority quality monitoring team and safeguarding team.

A Provider Information Return (PIR) had not been requested as this inspection had been bought forward due to information received. 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 spoke with 14 people who use the service, six relatives and a visitor. We spoke with 14 members of staff including care workers, administration staff, and two registered nurses. We also spoke with the registered manager, the nominated individual and two independent consultants who had been employed by the provider to help improve the quality of the service. We spoke with two health professionals visiting the service. We reviewed the care records and risk assessments for six people who use the service, the medicines

administration records (MAR) for eight people, recruitment records for five staff, and the training and supervision records for all staff currently employed at the service. We reviewed quality monitoring records, policies and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Although people told us they felt safe living in the home, we found the provider had areas for improvement with regards to safeguarding people. Staff understood they needed to report any concerns they might have about a person's safety to the registered manager, but they were not always sure what constituted a safeguarding incident. Staff were also not sure what they should do if the manager were unavailable, and we did not see any information around the home to advise staff and others about what they should do if they thought someone was at risk.

We observed two occasions where people's safety was put at risk, which staff did not identify. We informed the registered manager of our concerns and advised them they needed to make a referral to the local authority safeguarding team regarding these matters. The registered manager had a basic understanding of safeguarding people from avoidable harm and abuse, but had not reported all relevant incidents to the local authority, when they should have. People were not always protected from abuse and unsafe treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments and risk management plans were poor. Although the registered manager completed some risk assessments in areas such as nutrition, pressure ulcers and falls, they were not detailed enough. For example, the falls risk assessment used by the provider did not assess enough risk factors to determine the appropriate level of risk. One person was assessed as at low risk of falling, but appropriate footwear had not been considered for this person. They were seen walking in the lounge wearing shoes that put them at significant risk of falling. This had not been identified by staff. For three people, the risk of malnutrition had not been properly assessed. One assessment was not completed, a second stated the person was at low risk, when the provider's guidance stated they should be medium risk, and the third did not acknowledge the person's recent weight loss. In the two other assessments where the person was noted as at medium risk of malnutrition, there were no plans in place to manage the identified risk. The provider had identified a risk but did not take appropriate action to ensure the person did not become malnourished. They had not done all that was reasonable to reduce the risk as much as possible. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practices were not robust. Although all of the paid employees had a disclosure and barring service (DBS) check completed, the provider had not ensured that unpaid volunteers had also undergone the same checks. Even though volunteers are not strictly employees, they are included in the definition of employee for the purposes of the regulations. References to 'staff' and 'employees' therefore apply to volunteers and they should be subject to the same pre-employment checks as paid staff. A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. There were other gaps in the pre-employment checks, including lack of full employment history in three of the records we reviewed. No other checks were completed for volunteers. It is important for providers to undertake these checks before staff begin work to help ensure that staff employed by the service are, as far as possible, safe to work with the people they care for. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Incidents and accidents were not always fully investigated. For example, there had been three recent incidents of similar unexplained injuries. Although each incident was recorded, no analysis had been made of the incidents to see if there was any link between them. Although the registered manager told us they investigated incidents and took action where needed, they did not keep written records to evidence this. It is important to analyse and record investigations appropriately so the provider and staff can learn from adverse incidents and prevent them from happening again. This is an area of practice that requires improvement. Staff told us it was important to report incidents to a more senior member of staff and document incidents in the person's daily care report.

Medicines were not always managed safely. Most people's Medicines Administration Records (MAR) charts did not have a photograph of the person on the front. It is good practice to include a photograph of the person, so staff can be sure they are administering medicines to the right person. The registered nurse (RN) on duty said these were in the process of being updated. One person had declined to take one of their medicines for three weeks. Staff told us this was a regular occurrence for the person and the person's GP had been informed. However, a review of the person's medicines had not been completed and there were no records of the discussion with the GP in the person's care records. One MAR chart had been hand written and was confusing because some writing had been crossed out. The MAR had not been signed by two people, which is best practice when completing MAR charts by hand. This is to ensure that errors in a person's medicines administration are not made.

Medicines are sometimes administered to people in a disguised format without the knowledge or consent of the person receiving them. This is sometimes necessary and justified if it is in the person's best interests. Nine people were receiving covert medicines. The provider had not ensured that a pharmacist had been consulted to ensure the covert medicines were administered to each person in a safe way, or if there were any alternative forms of medicines, for example, liquids, instead of tablets. These were areas of practice that require improvement.

However, MAR charts were personalised and described how each person preferred to have their medicines. We observed medicines being administered. The RN administered the medicines safely, and gave a good explanation to each person about what the medicines were. Each person received their medicines in the way and order they preferred, as stated in their MAR chart. There was a safe procedure for storing, handling and disposing of medicines.

People who use the service, relatives and staff said there enough care workers on duty to meet people's needs, and we observed this most of the time. However, we found people with higher levels of care need were residing on the first floor of the home. Most of the staff were working on the ground floor and we only observed people on this floor being supported by staff at meal times and when receiving their medicines. There was a risk that people's care needs would not be met because staff were not attending to people who were more vulnerable frequently enough.

Environmental risks, such as fire and legionella were well managed, and the routine maintenance of equipment and the premises was up to date. The provider had an appropriate maintenance schedule in place to ensure essential works were completed when required in the future.

Requires Improvement

Is the service effective?

Our findings

Staff asked people if they would like support with their care. Staff made sure they asked for the person's consent before they began a task and respected the person's decision if they declined help. Staff gave people the time they needed to make a decision and came back again to offer an alternative.

However, people's care plans did not refer to their general level of capacity for day to day decisions, and there was minimal evidence of capacity assessments for decisions about specific aspects of people's care in their care records. This included covert medicines and the use of bedrails. Although there were some records to demonstrate decisions had been made in a person's best interests, and in accordance with the Mental Capacity Act (2005)(MCA), these were inconsistent.

The registered manager and staff had a limited understanding of the MCA and Deprivation of Liberty Safeguards (DoLs). This legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for them. For example, we saw beds that had rails up and staff had limited understanding of the need to assess people's capacity to consent to the use of bed rails. Staff has not considered whether the use of bedrails was in a person's best interest. DoLs aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Not all of the appropriate DoLs applications had been made to the relevant authority. All of the doors to leave the home had a key pad lock and people did not have the access codes to unlock the doors. There was a risk that people would have their freedom inappropriately restricted. There had been no consideration of people's capacity to consent to the locked doors. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not ensure they viewed and stored copies of people's Lasting Power of Attorney (LPA) or Court of Protection orders, if they had one in place. The registered manager told us one person's family member had an LPA and another a Court of Protection Order but was unable to provide any documentation to support this. It was not always clear who had the legal right to make decisions on someone else's behalf. An LPA is a legal tool that allows people to appoint someone to make financial or health and social care decisions on their behalf. The registered manager was unable to clearly demonstrate who had the legal right to make decisions on someone else's behalf. There was a risk that some decisions would be made by next of kin or family members who did not have the legal right to do so.

People's care records, including daily records, were stored on a central computer. Family members were given a password so they could access their relatives care plans and daily records. This was designed to allow family access to information about the activities their relative was taking part in, or how the person's health was. However, the provider had not considered people's confidentiality or if they consented to their records being accessed in this way. The provider did not have a way to ensure that computer access details were not passed onto to anyone they should not have been. These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff had completed training in the MCA and dementia awareness, the training had not always been effective. Staff tried to relieve people's distress or discomfort in a caring way. Although this was achieved on most occasions, there were times when staff lacked the appropriate skills to do so. This was because training in dementia care for staff was not detailed enough. For example, staff tried to reassure one person whose behaviour was causing them and other people some distress. Although they were talking to the person in a caring way, they did not support the person in the best way. The person's care plan did not provide any guidance for staff about how to support this person when they were distressed. It was clear staff were unsure of what they could do to support the person appropriately.

Staff told us they thought they had enough training and said they felt supported by the manager. However, the registered manager confirmed that regular supervision and appraisal had not been completed for at least 11 members of staff. It is important to provide staff with regular opportunities for reflective supervision and appraisal of their work. It enables staff to ensure they provide effective care to people who use the service. Continuous staff development is not only a requirement for meeting fundamental standards, it is also a vital element in ensuring that people receive the best care and support from staff. The registered manager was unable to demonstrate there were plans in place to address the ineffective training and to update supervision and appraisal. People were not receiving effective care based on best practice because staff were not properly trained. These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had referrals made to health care professionals when they were needed. We saw one person who was unwell and a staff nurse had ensured a phone call was made to the person's GP when this was noticed. Although referrals to professionals such as the tissue viability nurse were made, the provider did not keep records in people's care plans to evidence this. This is an area of practice that requires improvement.

People were supported to have enough to eat and to maintain a balanced diet. Food was homemade and nutritious and people gave us positive feedback about the food. One person said: "the food is fantastic". People were offered drinks at regular times through the day. However, we did observe some people in their rooms who did not have water or a cup within reach if they wanted to have a drink. One person who was alone in their room told us they were thirsty, but there was no water or glass available for them to have a drink from. We had to ask staff to support this person with having a drink. This is an area of practice that require improvement.

We spoke with the chef about how people were supported to have sufficient to eat and drink and maintain a balanced diet. The chef had a good understanding of meeting each person's individual needs. They were able to explain how they supported people with special dietary needs. For example, people who required soft or pureed food. One person had specific dietary needs due to their religion which the chef also catered for.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home said they were well cared for and they were treated with kindness and compassion by staff. Comments from people included: "the staff are kind" and "'they look after me well". Staff were gentle and respectful when talking to people or helping them with daily living tasks.

However people's dignity was not always respected. Choice of food was limited and people were not given the opportunity to make a decision about the food they wanted to eat that day. There were no menus available on either the wall of the dining room or on the tables, so people did not know what they were being served until the food was placed in front of them. This does not support people with dementia to make informed choices. The dessert that was served looked like mousse but was apple, cream and sugar. We asked a resident what their dessert was and they didn't know. A member of staff who had been supporting another person with their meal did not know what the dessert was either.

The registered manager had a very detailed knowledge of each person's care needs and preferences. They also spent time working as a registered nurse at the home, so they spent time caring for people on a one to one basis. This enabled the manager to really get to know the people using the service.

One person said: "I'm very well cared for here. All the staff are lovely". A relative told us that staff gave their spouse time and would sit and hold hands with them. When asked to describe the home the relative said: 'it is warm, caring and compassionate'. Other comments included: "staff are very pleasant". People had developed positive relationships with staff. Staff understood people's preferences and knew their personal histories. Staff described how they would support people in a person centred way to make day to day choices.

Staff were respectful and polite to residents, knocking on doors to protect people's privacy and explaining everything when supporting people to move. We observed several people being helped to move in a hoist. This was done gently and with care by staff, and staff made sure they explained what they were doing and maintained the person's dignity while they were being moved. People looked calm and relaxed while being moved.

People were well supported to make day to day decisions about their care, such as when to get up in the morning, what activities they may like to participate in and where and who to sit with in the lounge. There was a friendly welcoming atmosphere in the home and staff were calm and attentive to people and their relatives and visitors. People appeared comfortable and well cared for. People were dressed smartly and for those people that wanted to, nails were manicured and hair styled. Relatives and visitors were welcomed into the home and anytime and did not have their visits restricted in any way.

Requires Improvement

Is the service responsive?

Our findings

People's care plans contained basic information about their care needs and preferences. They were person centred in places but it was not clear how often they were updated. The provider was unable to demonstrate how people had been supported to be involved in their care plan, or what opportunities the person had been given to express their views about their needs and level of independence. Evidence of this was not contained in each person's care plan.

Care plans were written in a person centred way and staff knew people well and how to meet their needs. The registered manager told us a pre-admission assessment was completed with people and then their care plan was entered onto a computer. People did not have a printed copy of their care plan in their rooms to review if they wanted to, although the registered manager said this could be provided if the person asked for it. Most of the care plans had not been recently updated, and some of them contained out of date information. Staff did not have access to the most up to date information about people's care needs. This is an area of practice that requires improvement.

While complaints were investigated by the registered manager and a verbal response given to complainants, the registered manager did not follow the provider's policy when dealing with complaints. They did not keep records of their investigations, or what the outcome of the complaint was. They did not reply in writing to people who had made a complaint or record if they had met the required timescales when responding. Compliments from people were not recorded. There was no evidence of analysis of the complaints or evidence of learning from such events. It is important for providers to learn from compliments and complaints so they can make improvements to the service when needed. This is an area that requires improvement. People and their relatives were given information about how to make complaint when they moved in to the home and were advised they could contact the owner at any time should they need to.

People and those important to them had taken part in a quality survey conducted by an external company. Most of the feedback was positive and the survey showed the management and staff at the home were rated very highly. The survey had also highlighted areas that had improved since the last survey and some areas that had fallen. The final report recommended the provider should focus on improving the laundry service, 'smell management' and the homes atmosphere and entrance. On the first day of the inspection we noted a strong smell of urine on the ground floor and in some people's bedrooms, which demonstrated the recommended action had not been taken. The provider did not have an action plan in place to ensure areas identified for improvements from the survey were made This is practice that requires improvement.

Some of the activities were delivered in a way that did not best support people living with dementia. One person was given a painting to do. They were not asked if that was what they wanted to do and were not given the appropriate support to complete the activity in a meaningful way. We did not see any evidence of plans for future activities and there was no information displayed for residents to tell them what activities were available for the day, or planned for the future.

However there were some good examples of group activities available and one person said: "'the

entertainment is good here". On the day of our visit a singer was entertaining people. They interacted well with people, and staff joined in with the singing and dancing. People looked happy and were having fun. People were also being supported to knit, read a book and do puzzles.

Requires Improvement

Is the service well-led?

Our findings

Feedback about the registered manager was positive from everyone we spoke with, including people who use the service, relatives and staff. One relative said: "the manager is very pleasant and approachable'. Staff said they were well led and the registered manager and provider were accessible and listened to them. Staff also said any concerns they raised were dealt with quickly by the registered manager. Many of the staff had worked at the home for several years and said they worked together well as a team. All the staff said they liked working at Kettlewell House.

While the registered manager and provider understood that quality monitoring was important there were areas for improvement in their procedures. Most of the quality monitoring audits were completed by an external member of staff and not the registered manager. The nominated individual explained this was to free the registered manager up to allow them more time to build relationships with people, relatives and staff.

These quality monitoring systems had identified areas for improvement, however the registered manager and provider had not developed appropriate action plans to ensure action was taken when it was needed. Examples that had previously been identified in their own quality monitoring included lack of staff supervision and appraisals, errors in MAR charts and care plans not being regularly updated. These were all areas for improvement identified at this inspection. There was also a lack of recording by the registered manager for activities such as meetings with residents, staff concerns and care assessments, to evidence what actions had been taken to resolve any concerns raised. For example, some rooms smelt of urine where the carpet required cleaning. This had already been identified and no action had been taken. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager had been in post since October 2015. They had worked at the home prior to this as registered nurse for a year. During this time the registered manager was mentored by the previous manager and supported to gain the skills required to become the manager. It was clear the registered manager knew all of the people using the service extremely well, and they were very kind and compassionate when discussing individuals. However, the provider needed to offer further support and training to the registered manager to ensure they developed their knowledge and skills fully. This included manager level training in MCA and DoLs, safeguarding, and dementia care. During the inspection the registered manager confirmed they had appropriate dementia care training booked.

The manager and provider responded well to feedback given to them during the inspection and understood the challenges identified. They had already noted that the home's environment was not helpful for people with dementia. They had employed an independent consultant who specialised in dementia to help support them to improve the care they provided for people living with dementia who use the service.

The provider did not have any formal method of seeking feedback from staff, and they were not included in the survey completed by the external company. Supervision sessions and appraisals were not being regularly completed and there were no regular staff meetings. Staff were not given many opportunities to

provide feedback about the service. However, staff did tell us they could speak to the manager at any time if they needed to.

Not all of the registration requirements were met. The registered manager and provider had not ensured that all notifications were sent to us when required. For example they had not informed us of safeguarding incidents. Notifications are events that the provider is required by law to inform us of. They also help CQC to monitor the service between inspections. This is an area that requires improvement.

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 Nursing care Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person. Regulation 11(1)(7)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure they assessed the risk to the health and safety of service users or do all that is reasonably practicable to mitigate such risk Regulation 12 (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that service users were protected from abuse and improper treatment. Regulation 13(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Nursing care Personal care	The provider did not operate effective systems to ensure compliance with the regulations. Regulation 17(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure that all of the information under schedule 3 was available. Regulation 19 (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure employees received appropriate training, supervision and appraisal. Regulation 18 (2)(a)