# Purple Care Limited

# Lyndale

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

Lyndale is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Lyndale accommodates up to nine people in one building in a residential area of Bournemouth. At the time of our inspection two of these people were receiving personal care.

The people living in Lyndale have care and support needs associated with their physical and mental health.

The inspection visit took place on the 11 October 2018. The visit was unannounced. We continued to gather evidence from the home and professionals until 17 October 2018.

The service did not have registered manager. The previous registered manager had deregistered in May 2018. They remained involved with the home. 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.

We carried out this inspection in response to information of concern we received alleging that people were receiving unsafe and poor care in an environment that was in poor condition. During our inspection we gathered evidence that reflected these concerns.

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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

At this inspection, we found that risk management was not sufficient to ensure people received safe care and treatment. Risks related to people's skin damage and mental health were not being managed effectively and staff did not always have accurate information about these risks. Risks related to the environment had not been picked up and fire safety checks had not been carried out. This was a breach of the regulations.

Staff did not follow safe procedures and this meant people were at risk of not receiving their medicines as prescribed. Staff competency had not been adequately assessed to make sure they were able to administer medicines safely. Other staff training was not current including fire training and infection control. This was a breach of regulations.

People were supported to have choice and control of their lives. However, restrictive practices were not reviewed to determine if they were still appropriate. We have made a recommendation about this.

Notifications had not been made to the Care Quality Commission where required. This was a breach of the regulations.

Staff were able to respond to people when they wanted help. We also saw that the risk management related to staff recruitment was not robust.

People told us the food was adequate.

Care staff were kind throughout. Privacy was not always respected and failures to address environmental concerns did not reflect that people were respected or valued by a caring provider.

People told us they had access to GP's and dentists when they needed them.

People knew how to raise concerns but were not confident they would always be heard. Verbal complaints were not being managed in line with the organisational policy.

Oversight and governance in the home had not been effective in identifying shortfalls and unsafe practices. This was a breach of regulation.

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.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People's identified risks and infection control risks were not consistently managed.

People's medicines were not administered safely.

Recruitment systems were not robust.

People were supported by staff who understood how to protect them from abuse.

### Is the service effective?

**Inadequate**

The service was not effective.

The environment had not been maintained appropriately.

Staff supported people's choices about their day to day care, restrictive practices had not been reviewed.

People were supported by staff who had not had their training refreshed or their competency checked appropriately.

People had a choice of food and drinks available between 8am and 11pm that reflected their likes and dislikes.

### Is the service caring?

**Requires Improvement**

Is the service caring?

The service was not always caring, because people's privacy was not always respected and their dignity was not promoted.

People were supported by staff who they described as kind.

People were not supported consistently to maintain and develop their independence.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People told us they received their care and support in ways that suited them.

Care plans were personalised but had not been reviewed regularly with people.

People were not confident that concerns would be addressed. Verbal complaints had not been responded to in line with the organisations policy.

## Is the service well-led?

**Inadequate**

The service was not well led.

Auditing systems were not effective in identifying areas that required improvements.

Oversight and safety checks had not been carried out.

Statutory notifications had not been made to CQC.

# Lyndale

**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.

We carried out this unannounced inspection from 11 October 2018 to the 16 October 2018 with a visit to the home on the 11 October 2018. The inspection team was made up of two inspectors. The inspection was planned in response to information of concern relating to people's experience of care at Lyndale. We last inspected the service in November 2016 and at this time the service was rated good.

Before the inspection we looked at notifications we had received about the service. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We spoke with social care professionals to get information on their experience of the service.

The provider had not been asked to complete a Provider Information return (PIR) since their last inspection. This 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 were able to get up to date information during our inspection.

During our inspection we spoke with two people who used the service. We also spoke with the manager and three members of staff. We gathered feedback from health professionals who visited during the course of our inspection. We reviewed records related to two people's care. We also looked at records related to the running of the home including: four staff files, management audits, accident and incident records, training records, and policies.

We asked for further information to be provided to us following our inspection visit. This included training and recruitment information, information related to the safety and maintenance of the building. We received the majority of this information within agreed timescales.

Inadequate

# Is the service safe?

## Our findings

People told us they felt safe and made comments such as: "yes I feel safe" when we asked them about whether they felt safe. However, we found a number of concerns related to safe care.

Healthcare professionals had raised concerns about the management of risks associated with a person's physical health. There were current safeguarding investigations into whether this person's care and treatment had been neglectful.

We found that the systems in place to manage the risks this person faced were not sufficient. The manager told us they physically assisted the person with their health need once a week. They told us that district nurses also assisted the person physically once a week and that staff prompted the person to carry out the tasks they needed on the other days. They told us that this plan was sufficient and had been drawn up with the input of district nurses. What staff told us did not reflect this support plan when we asked about this aspect of the person's care. One member of staff told us that the person could manage this themselves and would ask for help if needed. They told us they would only need to prompt the person if they noted a problem. We asked district nurses if this support plan was sufficient. They told us that it was not and that the person remained at risk.

We reviewed the oversight of accidents and incidents. One person had put themselves at risk due to a deterioration in their well being. They had needed hospital treatment following an incident when they told staff they had drunk cleaning materials. During our inspection this incident was not reflected in the accident and incident records. The incident was not reflected in the person's care plan. Cleaning products were unlocked and accessible and one member of staff we spoke with was not aware of the incident. Emerging risks were not managed and people remained at risk of harm.

Fire safety risks had not been responded to appropriately. There had been a fire in the property in September 2018 that had started due to a fault in a dusty extractor fan. Since this event extractor fans had been cleaned but this had not been added to regular cleaning checks. Fire alarm checks had not been carried out since August 2018 and monthly fire blankets and extinguishers checks had not been recorded since July 2018. Information held to give to emergency services about who lives in each room and what their needs are was out of date. This may have put fire personnel at risk if the member of staff on duty was not able to communicate with them. We shared our concerns with the fire service.

We identified environmental risks were not safely managed and in some instances infection control measures were not being followed. Cleaning schedules did not reflect the cleanliness of the building and this put staff and people at risk of harm. A clean towel and soap were not available in a shared bathroom. We were told that a paper towel dispenser was being fitted shortly after our inspection. The stair carpets up to the staff sleep in room was loose and covered in dust. It represented a significant trip hazard to staff and this was not reflected on the risk assessment for these narrow stairs. Fridge temperatures had been not recorded on five days in October 2018. All the recorded temperatures since 28 September 2018 had been above the safe temperature detailed in the organisational policy. The manager was not aware of this.

We asked the manager to undertake a health and safety/maintenance audit and provide us with risk assessments related to the disrepair of the building. They did not identify the infection control issues associated with the bathrooms and did not sufficiently address risks. We shared our concerns with environmental health.

Medicines management was not robust and people did not always receive their medicines as prescribed. We looked at the medicines administration records for two people and found gaps in recording. In one instance this meant we could not ascertain how many tablets the person should have available. We could also not tell if they had been given their medicines as prescribed as staff had not signed to say this had been done. There were systems in place to address missed signatures but these had not been effective in improving staff adherence to safe administration processes. We also found that a person had gone without a prescribed medicine for a week and there was no recording indicating that this had been agreed with their GP. We were told by the manager that this had been due to a prescribing error.

The storage of medicines was not safe. The temperature of the medicines storage was not always recorded this was the case for five days in October 2018. There were 38 entries of medicines to be returned to the pharmacist since April 2018. None of these medicines had been returned. The manager told us that they had been planning to return these on the day of our inspection visit.

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

Staff recruitment processes were not robust. Recording about risk management related to recruitment was not sufficient. For example, one member of staff had not been able to provide a reference. The risk associated this had been considered but the mitigation not recorded. Another member of staff was recorded as having left the service and then returned. This meant checks would need to be made and references sought. The manager told us they had remained in continuous employment and they would review their safety checks. This was not reflected in the records.

People told us there were staff available to help them when they needed support. We discussed the staffing levels with staff and checked the rota. We heard and saw that there were usually the full deployment of staff but it was not possible to see which staff had been in the building. This was because the actual time staff worked was not recorded. The manager was on the rota form 0800 til 1800. They told us they usually worked between 0900 and 1700. During our inspection the member of staff working called the manager just before 1000 as they had not arrived yet or called to say they had been delayed. Health professionals who visited the home told us that they had also experienced the manager not being present when the rota indicated that they were. Whilst it was important that the manager was available to oversee staff and engage with professionals, they were also part of the staffing determined as necessary to meet the needs of people living in the home. It is important that there is a record of who is working in the home and an accurate reflection of when they were there.

Staff were able to explain how they would raise concerns about potential abuse or poor care practice within the organisation and were aware of the contact details of other agencies they may need to raise concerns with. They were able to describe signs that would indicate a person may be at risk of abuse.

Inadequate

# Is the service effective?

## Our findings

The premises had not been maintained to reflect the needs of the people living, or the staff working, in the home. Bathrooms were in disrepair. One person showed us their ensuite bathroom, the door leading to the bathroom was marked with dirt that had built up over time both on and near the door handle. There were tiles off the wall, peeling paperwork and the sink and bathroom floor showed evidence of not being cleaned for a sustained period of time with urine staining around the pedestal base. The person's care plan identified that they needed assistance with some cleaning tasks. They told us they were unhappy with the state of their bathroom and that they had raised this "a long time ago" with the manager. There was a discrepancy between the time the manger and the person told us the bathroom had been like this. The manager told us it had deteriorated suddenly: "six to eight months ago" the person reflected that it had been more than two years. At the last inspection in November 2016 this person's shower was not working and the inspector was told that the bathroom was scheduled for refurbishment. There was no risk assessment available regarding the hygiene risks associated with the bathroom being in this condition or the potential impact on the person's emotional wellbeing.

As a result of their own bathroom's disrepair, the person was sharing the downstairs shower room. This room also showed signs of sustained lack of cleaning with build up of dirt and stained grouting. The radiator in the room was rusted in one corner and the paintwork had peeled away. The toilet was slow to empty following a flush. A person who used this bathroom explained we would hear bubbling noises and that sometimes when the toilet was flushed waste water came up into the shower base. They told us that this was not a new problem. We heard air escaping from the shower. The manager explained that this was a problem with the drains and they asked a colleague to put cleaner down the shower drain. One of the people who used this bathroom had a wound site that they needed to keep clean.

Another bathroom had been damaged by a fire at the beginning of September 2018. The person living in the room continued to not have a main light working as these electrics were linked to the bathroom. The bathroom had not been cleared or cleaned since the fire and smoke staining was evident on the door frame with the door to the ensuite shut. The manager told us that this person had been asked not to open the door.

Another room had been vacated but the bathroom had not been cleaned. There was a urine stained bath mat and stained toilet roll visible. The toilet was dirty and the room smelled strongly of urine. We spoke with the manager who told us that the room had been left so that it could be decorated when someone new moved in. Another person living in the house had needed to use this room on a temporary basis whilst it was vacant.

We spoke with the manager about our concerns. They showed us that quotes had been sought for the work needed in the bathrooms. These quotes had been obtained at the end of September/beginning of October 2018. No builders had been instructed when we visited the home. The manager wrote to us following the inspection and told us that work had started on one of bathrooms.

Windows were not restricted. We spoke with the manager about this and they told us that no one was at risk because of this. We asked to see documented risk assessments related to this as identified at our last inspection in 2016. These were not available.

We saw that some aspects of maintenance had been raised with the provider, however, there was no regular audit of maintenance requirements available. We asked the manager to conduct a full check on the environment and record all maintenance and health and safety issues and send this to us with identification of when the work would be achieved. This check did not include individuals' ensuite bathrooms or equipment such as beds and bedding provided in a care home.

There was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt they had the skills, knowledge, experience and support to perform their roles effectively. Staff had access to training when they first started working at the service covering topics such as moving and handling, health and safety, infection control, safeguarding awareness, and dignity. Where appropriate they were undertaking the Care Certificate. This is a nationally recognised programme that seeks to ensure all staff working in care have the basic knowledge and skills needed.

The training matrix we were shown identified that most staff had training that was not up to date. The matrix identified that the 'core' training reflected mandatory training areas "stipulated by Skills for Care". Two staff had not refreshed safeguarding training in the two years and the manager told us the policy was that this should be done annually or biannually. The manager told us that this should be completed annually. Fire safety had just passed the year for the whole team. The manager told us they would be rebooking this but had not yet done so. One member of staff told us they had not had their medicines competency checked for over a year. The manager acknowledged that medicines competency assessments were required for some staff as the policy was to do these annually. They acknowledged that their own competency assessment was overdue and that they would need to address this prior to assessing the staff. The manager's health and safety, infection control and equality and diversity training were all overdue in line with the organisations time scales.

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

Supervision records were not available when we visited the home and these were sent through as requested. Records indicated that these provided an opportunity to discuss working practice and professional development. There was an acknowledgement by the manager that some supervisions were overdue in line with the organisational policy. There was discrepancy between how often staff told us they received supervision and the paperwork received.

People told us that the food was acceptable and we spoke with a member of staff who cooked for people and they knew people's tastes and preferences well. People had access to the kitchen during the day time to make drinks and snacks. The kitchen was locked at night. We asked the manager about this practice. They explained that it was a safety measure and that most people had the facility to make hot drinks in their rooms. We asked if the practice had been reviewed and they told us that it had always been the case and people were told that this was the situation before they moved in. They told us that prior to this people had eaten food at night that was needed in the day time. No food was left available for people during this time and the manager told us people were discouraged from waking the sleep in staff unless there was an emergency. Restrictive practices should be reviewed within the framework of the Mental Capacity Act 2005.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

The staff and registered manager told us that everyone in the home could make decisions about their care and support. When people's mental health deteriorated and this impacted on their ability to make decisions mental health professionals were involved.

We recommend you review restrictive practices to ensure that consent is ongoing where people are able to agree to measures in place. We also recommend you consider ways of reducing the impact of any restriction deemed necessary to ensure people's rights are respected.

The people receiving personal care had been living in the home for many years. They told us they were happy with the way their care and support was managed. Assessments related to their mental health had been incorporated into their care plans.

People told us that the doctor was called if they were unwell and that they could see a dentist if needed. Health professionals told us that where supplies were needed to enable a person to maintain their physical health these were not always made available. They told us that although they had prompted the need to order these supplies action had not been taken and this had led to a delay in a treatment the person needed.

Requires Improvement

# Is the service caring?

## Our findings

The failure to maintain the environment did not promote the dignity of people living in the home. The lack of cleaning and maintenance reflected a lack of respect for the people using these rooms. The provider had been made aware of the maintenance issues identified in the home. They had not taken appropriate action to ensure people were provided with an environment that was clean, safe and upheld their dignity. We saw that bedding available for people and staff was also stained. This did not reflect the characteristics of a caring provider.

We had to remind the manager not to talk about people within earshot of others.

There was breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were treated with kindness by staff. All the interactions we observed throughout the inspection demonstrated this. People responded as if this was normal and natural, in line with their usual experience. One person told us: "It is a happy place. We all get on here." Another person told us "The staff are kind." There was a calm atmosphere in the home with enough space for people to engage with each other in the communal lounge or to spend time in their individual rooms.

The kindness of staff was echoed when staff spoke about people with us. People recognised and felt comfortable with staff. We saw people sought out staff by coming to the communal area of the home. People told us they had built up strong relationships with some staff. One person commented on one member of staff identifying that they were "all for our rights". They told us how much they appreciated this. Staff told us they had a good understanding of people, their personal backgrounds and histories, their interests and preferences. Information about people's histories was also detailed within people's care records.

People were able to have visitors in the home.

Support to retain independence was not always clear. Where people needed help to undertake tasks such as maintaining the cleanliness of their rooms this had not always been provided. This did not support people to direct their own lives or enhance their independence.

We recommend you review support plans to ensure that people's autonomy and opportunities for skill maintenance and development are clearly reflected and monitored.

Requires Improvement

# Is the service responsive?

## Our findings

Staff were available to provide support to people when they wanted it.

People's communication needs were known to staff and people were able to communicate verbally unless their health had deteriorated.

People told us they were able to raise concerns with the registered manager or staff. However, we heard that people were not confident that their concerns would be addressed. One person gave an example of getting work done in their room and said they had been asking for a very long time. Another person identified that some staff were more responsive than others. We asked the registered manager about this they told us people may have raised concerns with the wrong people. They also told us they did not record people's verbal complaints. This was not in adherence with the provider's policy on complaints.

House meetings were held infrequently and people had the opportunity to discuss issues that affected them as a group at these meetings. Meetings that were meant to be held monthly between keyworkers and people also afforded people the opportunity to raise concerns. These meetings were not happening regularly and we saw that people had not had these meetings for periods of more than five months. This meant that an opportunity to identify things that mattered to people and that they may wish to be changed was being missed.

Support plans were individualised to the person according to their needs and preferences. They included information about people's life histories and reflected their preferences. Support plans described the help people needed and what they could do for themselves. They covered areas including, personal care, eating and drinking, health conditions and staying safe. People did not always receive support as outlined in these plans and staff did not share a common understanding of how to provide support for people.

Care plans did not sufficiently cover what activities people found meaningful or the support they would need to follow their hobbies and interests. There is a risk that if this information is not recorded or appropriately monitored that opportunities for people to engage in activities will be missed. People went out and about, spent time in their rooms or sat chatting with each other or staff during our inspection. There was a member of staff leaving on the day we visited and this was marked with a communal buffet lunch.

Inadequate

# Is the service well-led?

## Our findings

When we last inspected the service in November 2016 we judged the home to be good in all areas. At this inspection we found that oversight of the quality and safety of the service had deteriorated substantially.

The provider organisation was made up of the owner. We were told by the manager that the provider had contact with the home on an almost daily basis and were kept apprised of events in the home. The manager provided us with a report they had sent to the provider in August 2018 identifying recent events and highlighting refurbishment works that were needed.

The manager in the home had applied to become registered with the CQC. The previous manager had deregistered in May 2018, they retained contact with the service and were available to the current manager for advice.

Governance systems had not been effective in identifying and addressing concerns highlighted through our inspection such as failure to carry our fire checks in line with guidance. Environmental issues had not been addressed appropriately or with respect for the people living in the home. Care plans had not been reviewed with people and this meant it was not possible to determine when changes to care plans had been made.

Where actions had been identified as necessary following auditing these had not been actioned. A private consultant had been employed to review the service. They had visited in May 2018 and supplied a report detailing areas for action. The majority of these issues had not been addressed sufficiently. For example, they had identified that risk assessments were needed regarding the lack of window restrictors and that the current manager should add their contact details to on call information. Neither of these actions had been taken when we visited. Medication issues flagged regarding the bringing forward of balances and gaps in recording remained of concern during our inspection. They had also highlighted that the training matrix needed updating. Whilst the information was available to the manager that these issues needed attention they remained unaddressed when we visited.

We spoke with the manager and they acknowledged that they had not been on top of oversight. We asked about how the reviewed the care delivery and safety in the home in terms of checks and audits. They told us that as a manager they tried to be reflective and they had plans to instigate a lot of the issues we were raising. They told us they had not done a health and safety check recently and acknowledged that they were not regularly or frequently checking if keyworkers were carrying out their review tasks.

They told us they had a service development plan and they would send it to us as it was not available in the building. We reviewed this and found that issues identified by different agencies and internal processes had been added. There were actions recorded related to the training matrix and medicines competency, personal evacuation plans and medicines protocols. We noted that a number of these tasks had been signed as completed but at the time of our inspection required further attention. There had been no additions to the plan since April 2018. The service development plan was not an effective tool in ensuring people's safe care and treatment and sufficient governance of the building and staff team.

The registered provider had not assessed or monitored the quality of the service effectively. Where shortfalls had been identified by the manager or consultant they had not taken action to ensure that tasks had been completed, as part of their oversight and governance of the home.

Policies did not provide a framework of care delivery and governance in the home. Policies had not been updated to reflect changes in legislation, the majority of policies were last reviewed in 2010 and as such did not reflect Equalities Act. We also noted that where policies were clear about actions required this was not always adhered to. For example, the fire policy detailed that fires should be notified to the CQC and the complaints policy detailed that verbal complaints should be recorded.

Records were not accessible at the location. During our inspection a number of staff records and governance documents had been removed from the home by the previous manager and owner. These were provided as requested after our visit. District Nurses fed back that they had seen a member of staff unable to access care records relating to a person who was being admitted to hospital because they were on a computer they could not access. This meant ambulance staff could not be given up to date information.

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

There had been a failure to notify CQC about incidents that had disrupted the service. A fire and incidents reported to us by staff where the boiler had not worked had not been reported. This meant that CQC had not received information to support their monitoring of the service.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2010.

People were comfortable with the manager. They also told us they liked the staff and the people they lived with.

Feedback from professionals working alongside the service indicated that they had not been able to engage with the manager. They told us that requests were not followed up and information was not communicated effectively amongst the staff team.

Following our feedback, the provider and manager wrote to us detailing work they had started to address the shortfalls found during our inspection. This included planned changes to the oversight of the service.

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 18 HSCA RA Regulations 2014 Staffing<br><br>Persons employed by the service did not have appropriate training and support.<br><br>Regulation 18 (1) (2) (a) |