Health and Home (Essex) Limited

Alexander House Private Nursing Home

Inspection report

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Westcliff On Sea
Essex
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Tel: 01702346465

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

What life is like for people using this service:

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

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

Medicines were not stored safely.

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

People's individual protected characteristics were not clearly identified.

Staff members did not feel supported by the management team and did not feel there was appropriate guidance on how to provide 'best care'.

People's privacy was not always respected.

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

The provider did not have effective systems in place to monitor the quality of the service they provided or to drive improvements where needed.

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

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

Staff members had access to training. New staff members completed a structured introduction to their role. However, staff members did not demonstrate the practical application of their training in terms of the support they delivered.

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

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

Rating at last inspection: Good (Last report published 22 June 2016). Following significant concerns regarding people's safety the current rating is 'inadequate' overall.

About the service:
Alexander House Private Nursing Home is registered to provide accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury for up to a maximum of 26 people. At this inspection 22 people were living there some of whom were living with dementia.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Alexander House Private Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Service and service type
Alexander House Private Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At this inspection 22 people were living there.

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

Notice of inspection
This inspection took place on the 18 November 2018 and was unannounced.

What we did:
Before our inspection visit, the provider completed a Provider Information Return (PIR). We used this as part of our planning. The (PIR) is a form that asks the provider to give some key information about the service,

what the service does well and improvements they plan to make. We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

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

During the inspection we spoke with eight people, one relative, the registered manager (who is also the director), three care staff workers (including one nurse) the cook and the provider. We reviewed a range of records. This included two people's care and medication records. We confirmed the safe recruitment of one staff member and reviewed records relating to the provider's quality monitoring, health and safety, compliments and complaints.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management, systems and processes
• We saw fire doors, used to prevent the spread of smoke or fire, were poorly maintained and did not provide assurance that people would be safe in the event of an emergency.
• We saw fire doors with broken self-closures which prevented them from effectively closing in the event of a fire alarm activation.
• Fire doors did not have appropriate smoke strips fitted which would help prevent the spread of smoke in the event of a fire. For example, the kitchen door and the door access to the stairs did not have smoke seals on them.
• The fire plan, which detailed people's personal bedroom locations for staff to refer to in an emergency, contained inaccurate information. For example, room numbers on the fire plan did not correspond with the numbers on bedroom doors. This could put people at risk in an emergency as the information was confusing.

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

• We saw some light fittings that did not have light bulbs in them. These were in areas accessed by people living at Alexander House Private Nursing Home and by staff members. There was no emergency lighting in this area which would turn on at such times, for example, in the event of a fire to help people evacuate. We asked staff members about these. No one we asked could tell us how long they had been broken or what action had been taken to repair them. We asked the provider about this area. They said, "You tell me what I need to do and I will get it done." However, their systems and processes were inadequate in identifying and correcting issues with the environment which put people at risk of harm in the event of an emergency.

Preventing and controlling infection
• People were at risk of harm from infection as the physical environment at Alexander House Private Nursing Home was, in places, in a poor state of repair.
• We saw staff members did not follow best infection prevention and control practice when working. For example, we saw a staff member using a sluice facility located on the first floor. This staff member told us they had just supported a service user with their personal care. They were wearing the same gloves they had worn when completing the personal care task. This staff member was carrying clinical waste in a plastic bag. The foot peddle on the clinical waste bin was broken and we saw the staff member shut the lid by hand whilst wearing the same gloves. They then removed the gloves and placed them in their pocket, whilst closing the door of the sluice facility using the same handle they had touched when entering. There was no facility available to this staff member to wash their hands. We asked the staff member about their techniques and they told us, "No one ever checks us. There is nowhere up here to wash our hands." The lack

of appropriate storage of clinical waste and poor practice of staff members put people and staff members at risk of contracting infectious illnesses.

• The sluice area was in a significant poor state of repair and was not fit for use. The bins used to store clinical waste were heavily rusted and soiled. The foot pedal used to operate the lid of one bin was broken resulting in staff members having to use their hands to open and close the bin. The tiles on the wall were broken and the pull cord for the light and for the toilet system could not be effectively cleaned. One person living at Alexander House Private Nursing Home came over to this area whilst we were there. They said, "Look at that, it's disgusting, isn't it?"
• The sluice area was not securely locked putting people at risk of harm. When we left the sluice area we used the sliding bolt on the outside to secure the area. A short time after a staff member came over and said, "Who keeps locking this door?" The practice of staff members in not securing access to the sluice area put people at risk of harm.
• The sluice area was cluttered and access to the sides, rear and floor areas of the room was restricted which prevented effective cleaning and infection prevention and control practice which puts service users and staff members at risk of contracting infectious illnesses.
• We asked staff members, the registered manager and the provider about this area. All those we spoke with confirmed that this was the only area for the storage of clinical waste at Alexander House Private Nursing Home.
• The provider told us they had not checked the area for some time so did not know what it was like. The provider's systems and processes were ineffective in keeping people safe from infectious illnesses.
• Throughout our inspection site visit we did not see staff members wearing any protective aprons when working with people. This poor practice put people and staff members at the risk from contractible illnesses.

• We saw one person's commode was heavily soiled with an unknown substance, and was rusted. There was no effective cleaning programme in place to prevent the spread of infectious illness. For example, there was no effective system to clean this piece of equipment after each individual use.
• The baths at Alexander House Private Nursing Home had worn enamel exposing the surface beneath which prevented effective cleaning. The hoists used to support people into the bath were rusted with the surface below exposed.
• The hand rails located beside the toilet in the shower room were extensively rusted which prevented effective cleaning putting people and staff members at risk of contracting infectious illnesses.
• The communal weighing scales chair was rusted which prevented effective cleaning and infection prevention and control putting service users and staff members at risk of contracting infectious illnesses.
• Some of the over chair tables, which some people used to eat their meals from, were chipped and in a poor state of repair. For example, some had missing adjustable height risers and the adjustable feet, used to stabilise the tables, were missing. We asked the registered manager about these and they told us there was a programme of redecoration. However, they could not provide us with any reassurance that they assessed, identified and then rectified faulty pieces of equipment people used as part of their day to day support.
• The registered manager and the provider had failed to ensure that staff members had the equipment needed to follow best infection prevention and control practice. For example, we saw one member of the domestic support team used the same mop and bucket throughout the home. We asked them if they had colour coded pieces of equipment for different areas in accordance with the Department of Health guidance. They told us they only had the one piece of equipment that they used throughout the building. This put people at risk of contractible illnesses.

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

• People's medicines were not securely stored. We saw the key to the secure medicines fridge was broken. We asked a staff member about this. They could not tell us how long the key had been broken. The registered manager could not provide us with a timescale for how long this piece of equipment had been faulty.

Learning lessons when things go wrong
• The provider reviewed any incidents or accidents to see if any further action was needed to minimise the risk of reoccurrence. However, neither the provider nor the registered manager had acted to recognise and replace unsafe equipment and carry out repairs to the physical environment at Alexander House Private Nursing Home. They had not assessed or corrected staff members' practice nor had they observed or overseen safe working procedures at Alexander House Private Nursing Home to ensure people received safe care and support.

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

Staffing levels
• People told us that they were supported by enough staff to meet their needs promptly. However, one staff member talked with us about the pressure they felt they were under. They said this was because of changes to the number of qualified nurses available at Alexander House Private Nursing Home. We asked the staff member if they had discussed their concerns with the registered manager or provider. They told us, "The decision has been made so I will just get on and do it. But I don't think we have the time to do what needs to be done."
• However, people told us, and we saw, they received support when they needed it and that they were responded to promptly by staff members supporting them. One person, who chose to spend time in their room, told us that staff members came when they requested support.

Using medicines safely
• The registered manager had systems in place to respond to any potential medicine errors. Staff members told us they had been assessed as competent before supporting people with their medicines. People we spoke with told us they received their medicines on time. The medicine records we looked at were accurately completed. However, medicines were not securely stored.

Requires Improvement

Is the service effective?

Our findings

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

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

Adapting service, design, decoration to meet people's needs
• The physical environment at Alexander House Private Nursing Home did not meet people's individual needs. At the time of this inspection a number of those residing there were living with dementia and some had reduced sight. There was a lack of suitable signage for people to orientate themselves to their surroundings. Walls, floors and doors to bedrooms, bathrooms and toilets were not distinctive. There was no personalisation of people's individual bedroom doors to assist in their orientation or mobility. Some bedroom doors had the name of the person who had previously resided in that room. Some of the bedroom doors had confusing numbers on them. For example, two bedrooms had the same number on them. The bedroom numbers were indicated by handwritten sticky labels which were unclear to those with reduced sight.
• The floors on the ground floor and first floor had a substantial slope which was poorly defined. We asked the registered manager about the slope and how this had been considered in terms of making the areas safe for people with reduced sight. They explained the difficulty they had when making alterations to the building, but had not considered this as part of the plans for redecoration.
• Neither the provider nor the registered manager had plans to make the physical environment at Alexander House Private Nursing Home more suitable to those who lived there.

Staff skills, knowledge and experience
• New staff members completed a structured introduction to their role. This included completion of induction training, for example, infection prevention and fire awareness. In addition to this, they worked alongside experienced staff members until they felt confident to support people safely and effectively. However, despite the management team telling us that all staff members were trained in infection prevention and control, we saw several incidents of poor practice.
• The registered manager and the provider did not have systems to effectively assess the competency of staff members or to appropriately supervise them to ensure that they were following best practice in health and social care.
• The registered manager told us staff members new to care were supported to complete the Care Certificate. The Care Certificate is a nationally recognised qualification in social care. However, the staff members we spoke with told us that they had not completed the Care Certificate.

Staff providing consistent, effective, timely care
• Staff members passed information between themselves as part of a handover at the end of one shift and the start of the next. This information contained details about the person and the support they had received and any medical or personal issues which still needed to be considered.

• However, staff members we spoke with told us that they did not routinely read people's care and support plans, but used these handover meetings as a means of understanding the current needs of people.
• All those we spoke with told us they thought the staff members supporting them understood them and met their needs well and in a timely way.
• People had access to healthcare services when they needed it. This included foot health, GP, district nurses and opticians. The provider referred people for healthcare assessments promptly if required.

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

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

Supporting people to eat and drink enough with choice in a balanced diet
• People were supported to have enough to eat and drink to maintain their well-being. When it was needed the staff team monitored people's food and fluid intake and referred onto healthcare professionals for advice and guidance. For example, to the GP or dietician.

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence
• The overall valuing of people as individuals was compromised by the provider's inaction to identify or address aspects of the physical environment within which they lived. For example, people were expected to eat their meals from over chair tables which were chipped, stained and showed signs of fluid egress. This did not demonstrate that the provider had embedded a valuing and dignified approach to the care they provided for people living at Alexander House Private Nursing Home.
• When people were able, they were supported to maintain their independence. One person said, "I'm quite independent here. I have a wash in the morning which is my choice and I do it all myself. I don't need help."

Supporting people to express their views and be involved in making decisions about their care
• People were not routinely supported to express their individual likes and dislikes. For example, people were only provided with one option for lunch. The meal was provided to people without any description from the staff members supporting them and they were not asked if they liked what was on offer or if they preferred something else to eat.
• We saw information which was confidential to the person was kept securely and only accessed by those with authority to do so.

Ensuring people are well treated and supported
• People told us they were supported by a kind and compassionate staff team. One person said, "They (staff) are very kind. I have nothing to complain about." Another person told us, "They (staff) look after me very well."
• The provider did not have effective systems in place to identify and support people's protected characteristics from potential discrimination. Protected characteristics are the nine groups protected under the Equality Act 2010. They include, age, disability, gender reassignment, marriage and civil partnership, religion etc. The care and support plans we saw did not clearly identify people's individual characteristic nor did they detail what the management team were doing to promote such aspects of people's lives. Staff members we spoke with could not tell us about people's cultural background or not how they supported them to maintain their own personal identities.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

RI:□People's needs were not always met.

How people's needs are met

Personalised care
• People did not always receive information in a way they found accessible. At this inspection Alexander House Private Nursing Home was providing support for those experiencing hearing loss, sight loss and those living with dementia. However, the provider had failed to implement the Assessible Information Standards.
• From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. The registered manager was aware of these standards and in the change in the law regarding them. However, they had not reviewed the care and support plans for people or amended how they assessed and supported people to effectively meet their needs.
• On the day of this inspection we saw people engaged in a chair exercise session which was completed by an external facilitator. However, people we spoke with told us they would like to be involved in more activities as there was little to do throughout the day. One person said they liked art "but this had not been offered for a long time". Another person told us, "They (staff) don't take me out very often." There was no information available to people on what activities were taking place and when and therefore could not make effective decisions about what to be involved in. Staff members told us there was no one staff member with the responsibility of completing activities with people. They went on to say they played board games or cards with people if they had time, but often they were busy providing personal care which limited their time. One relative, who's family member stayed in their room, told us their family member never got any one to one interaction or activity with staff. People were not routinely engaged in activities that they found to be interesting or stimulating.
• We saw people had individual care and support plans that reflected their personal needs, likes and dislikes and how they preferred to be supported. However, staff members we spoke with told us that they did not routinely read these plans as they didn't get time and that they relied on handovers to receive information about people and their current needs.

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

End of life care and support
• At this inspection no one was receiving and of life care at Alexander House Private Nursing Home. The registered manager told us that should someone approach the end of life then their care planning process

would seek to access and support them to meet their needs.

Inadequate

Is the service well-led?

Our findings

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

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

Leadership and management
• We identified significant shortfalls in the quality of leadership and management which impacted on people using the service.
• The registered manager, although known to people and staff members, did not have an effective presence within Alexander House Private Nursing Home. For example, they did not know the individual rooms where people slept. When asked the registered manager was confused and could not tell us who was in a room because the name on the door did not correspond with the person who was staying in there. As it transpired the person was in hospital at the time of us asking which was not known by the registered manager.
• The registered manager did not correct staff members on poor practice when they saw it. For example, the registered manager failed to correct staff when they saw staff members wearing gloves for personal care and support and then move onto another task without changing them. We asked the registered manager about their training in infection prevention and control and the application of best practice. They told us they were not a trained clinician and had not completed this training.
• The quality checks completed by the management team and the provider were ineffective in identifying improvements needed in the service that people received. For example, the provider failed to act to identify and correct significant shortfalls in their fire prevention systems and the infection prevention and control issues which put people at risk of harm.
• The management team and the provider failed to undertake effective quality checks of the infection prevention and control systems in place at Alexander House Private Nursing Home. The provider could not tell us what they were intending to do to rectify the issues we identified to provide safe care and support for people.
• We asked them what protocols they followed for ensuring people were safe and that staff members followed best practice. The provider was not able to tell us about recognised policies or current practices. People were at risk of harm from poor fire safety and infection prevention and control as the provider did not access current best practice in these areas.
• Maintenance issues reported to the management team, and the provider, were not addressed in a timely manner, putting people at the risk of harm. For example, they were unable to tell us when missing light bulbs would be replaced or what action had been taken to rectify the broken lock on the secure fridge for storing people's medicines.
• The provider's quality monitoring was not effective in identifying the concerns that we found at this inspection. The registered manager told us that they were planning to redecorate the communal areas of Alexander House Private Nursing Home. We asked about the consideration to best practice in making the environment accessible and suitable to those living with dementia. However, they were not able to describe how they intended to incorporate these considerations into the home.

Continuous learning and improving care
• The registered manager told us that they kept themselves up to date with developments and best practice in health and social care. However, they had not implemented the accessible information standards for people living at Alexander House Private Nursing Home. They could not demonstrate to us what the recognised best practice was regarding effective infection prevention and control was, they did not demonstrate a working understanding of effective fire safety prevention and they had failed to act to ensure the premises at Alexander House Private Nursing Home was safe for people to live in.
• The registered manager did not have effective systems in place regarding the failure to address when things went wrong. For example, they did not have a means to escalate concerns regarding the unsafe maintenance of the location to the provider to resolve the issues we have highlighted as part of our inspection.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong
• Staff members we spoke with told us that they had raised issues regarding the physical environment of the home with the provider. One staff members said, "I don't know what to do. I have already said it and nothing happened. No one takes responsibility for sorting anything."
• The provider did not have effective systems in place to promote high quality care and support. The provider failed to assess the quality of people's experiences including meal times and activities. The registered manager failed to correct unsafe staff practice and behaviour. The provider failed to act when issues had been raised with them to make the property more suited to those that lived there, including making the establishment safe for people to live in.
• We spoke with staff members about policies and procedures which impacted on their daily work including the whistle-blowing policy. One staff member told us, "I suppose if I was concerned about something I could always ring the police."

Engaging and involving people using the service, the public and staff
• The provider did not have effective systems for gathering people's views of the service that they received. The provider had previously completed a resident satisfaction survey. However, they failed to act on the issues raised within the survey. For example, one family member asked for paper towels or something to be put in their relative's room so that they could wash their hands and dry them. No action had been taken in response to this request despite the survey having been completed some months earlier and the relative had not received any feedback from the management team.

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

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

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

Working in partnership with others
• The management team had established and maintained good links with the local community and with

other healthcare professionals which people benefited from.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The providers fire safety and infection prevention and control processes were not effective in keeping people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to provide good care.