Sunnycroft Care Home Limited

Sunnycroft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 and 27 October 2016 and was unannounced.

Sunnycroft provides care for up to 37 people. The home supports older people many of whom are living with some forms of dementia. The accommodation comprised of a purpose built property connected to a bungalow and a house.

The current manager had received confirmation of being the registered manager on the day of our visit. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. During this report the registered manager will be referred to as the manager.

People's medicines were not always stored in a safe way. This posed a risk to certain people who lived in the home. People didn't have thorough risk assessments and reviews. Some risks to the people who lived in Sunnycroft had not been fully explored.

There was no robust system to assist staff to respond to emergencies in the evenings and weekends. The manager and the provider did not have effective systems to test the quality of the service provided. There was a lack of action plans to enable the development of Sunnycroft.

The service was not fully responding to people's social needs that lived in the home. There was a lack of social stimulation for many people in the home. Staff did not have the time to spend talking with people. The service had not considered ways to engage with people and seek their views on the service.

There was a lack of monitoring and testing that staff had the knowledge and skills to meet people's needs.

These issues all contributed to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People benefited from being supported by staff who were safely recruited, trained and who felt supported by the manager. There were enough staff to meet people's physical care needs.

Staff understood how to protect people from the risk of abuse and knew the procedure for reporting any concerns. Most staff were aware of people's health needs and followed guidance to meet these needs.

Staff assisted people with kindness. People's dignity and privacy was maintained and respected.

The Care Quality Commission (CQC) is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. The service was depriving some people of their liberty in order to provide necessary care and to keep them safe. The service had made applications for authorisation to the local authority DoLS team and was working within the principles of the MCA.

The service encouraged people to maintain relationships with people who were important to them. People's relatives and friends were welcomed to the service and encouraged to visit.

There was a positive culture and a friendly atmosphere at Sunnycroft. The manager was motivated to make positive changes.

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.

Medicines were not always stored in a safe way.

People did not always have robust risk assessments.

There were enough staff to keep people safe.

People were supported by staff who knew how to prevent, identify and report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

There were limited systems in place to test and monitor staff competency and knowledge.

Not all staff communicated effectively.

People had enough to eat and drink.

People's health was maintained by having access to appropriate professional healthcare services.

Is the service caring?

Good

The service was caring.

Staff delivered care in a caring manner.

Care and support was provided in a way which promoted people's dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care assessments and reviews were not always up to date and person centred.

Most people did not experience regular social stimulation. Some people felt socially isolated.

The service encouraged people to maintain meaningful relationships with those close to them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of auditing systems in place to ensure a good quality service was delivered.

The service did not have systems in place to regularly gain people's views on the service provided.

The staff felt supported by the new manager.

The manager was motivated to make changes to the home.

Sunnycroft Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 26 and 27 October 2016 and was unannounced. The inspection was carried out by two inspectors 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.

The registered manager had completed a Provider Information Return (PIR). 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.

Before we carried out the inspection we reviewed the information we hold about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law.

During our inspection we spoke with nine people who used the service. Observations were made throughout the inspection. We also spoke with five relatives and a visiting health professional.

We spoke with the manager and six members of the care staff. We also contacted the local safeguarding team, the local authority quality assurance team, and the clinical commissioning team (health) for their views on the service.

We reviewed the care records of five people and the medicines records of six people. We also looked at records relating to the management of the service. These included training records, health and safety check records, audits, accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

Some people's needs were not always managed in a way that consistently kept them safe. A member of staff told us that one person had a history of self-harming. We looked at their care records and there was no risk assessment identifying and managing this potential situation. We spoke with the manager about this; initially the manager told us they were not aware of this. However, when we spoke further with the manager they told us this person had expressed intentions to self-harm to staff and themselves. From speaking with the manager and looking at this person's record there was no plan in place to support this person and manage the risks, when they were distressed.

During our visit we observed that a product used to thicken people's drinks and prevent them from choking was left unattended and unsecured. If this product was ingested by accident this could cause a person to choke. Most people who lived at the home were living with some form of dementia. We asked the manager about this risk. The manager told us that this product should either be in the secure medication room or in a secure container in people's rooms. We explained this was not the case. We asked the manager if some people were at risk of ingesting this product. The manager said, "They are all at risk." We asked what they planned to do about this issue. The manager told us they had purchased lockable cupboards for people's rooms and these were ready to be fitted. We were told the cupboards had been purchased some months ago and they had at present not been fitted in people's rooms. During our visit a cupboard had been fitted in one person's bathroom to store the thickener. However, this happened after we had addressed the issue. We also noted another thickener remained in an accessible kitchenette despite informing the manager about our concerns.

We also noted that the remains of one person's drink, who had thickener added to it, in order to prevent them from choking. This liquid was extremely thick. This was left in their open room. If swallowed this could cause someone to choke.

The above concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had mixed views when we asked people if they felt safe. One person said, "I don't feel safe because I feel so alone." However, we spoke with some other people who told us they felt safe. One person said, "I feel safe and reassured, excellent carers, I'm quite happy, as I can be." One person's relative told us, "[Name] is safe, that's all I can ask for."

The manager and staff had a system of reporting on accidents and incidents. If a person had fallen for example this would be recorded. The form prompted the member of staff if action was needed such as calling the GP. However, we looked at a sample of these documents, a person had had two falls recently but no GP had been called and no onward referral to the falls team had been recorded.

Some of the people we spoke with felt there were not enough staff to meet people's needs. One person told

us what happens when they press their alarm bell, "They come and tell me that they're busy, but they don't come back quickly enough." A further person told us, "That bloody noise. It bothers everyone, it won't stop, you won't get it going off very quickly, and that I know."

The staff we spoke with told us there were enough staff on shift to meet people's physical needs. The manager told us they had not assessed how many staff were needed on shift to meet people's needs, this was the provider's decision. The manager told us how they had recently increased the night staff from three to four. This was because members of staff had told them there were insufficient numbers of staff on shift at that time. The manager said they negotiated this increase with the provider. Staff told us who completed night shifts that this was an improvement.

There were safe recruitment processes in place, which ensured only those people suitable to work in care, were employed. We looked at the personnel files of the most recent members of staff to work in the home. We saw that appropriate security checks had been completed. Some staff were employed via an agency. We looked at some of these people's records which demonstrated their work history.

The manager did not have an emergency contingency plan for the home. There was no clear information for the senior on duty at weekends or team leaders working on the evening shifts to follow, if there was a sudden event such as a power failure or extreme weather. There was an on call system whereby staff could contact the manager or provider by telephone for advice. However, the manager told us that they would not be able to attend the home quickly in the event of an emergency. The manager told us that they would consider a new emergency contingency plan so that staff had clear guidance about how to deal with emergency situations.

Most of the staff we spoke with were confident and knowledgeable about how to protect people from the potential risk of abuse or harm. Staff were able to tell us how they would identify if a person was experiencing harm in some way. Staff also told us they would inform the manager if they had concerns. Some staff knew they could also contact the local authority (social services). However, two members of staff needed prompting and assistance in answering our questions regarding protecting people from harm. We were not confident about their knowledge and understanding in this area.

There were safety checks carried out by a member of staff to ensure people and the premises were safe. We were shown records which showed there were regular fire safety checks carried out. On the day of our visit the fire alarm was tested and an electrician was visiting as part of a yearly test of the electrical items in the home. We could see specialist equipment to support people to transfer from one position to another had been tested. We could also see the water temperatures in people's rooms had been tested.

On the day of our visit we observed medication was administered in a safe way. We observed a team leader administer people's medicines and we looked at people's Medication Administration Records (MAR). On this day we found that people had received their medicines as the prescriber had intended. We saw a team leader checking people's MAR charts at the end of administering people's medicines to check this had been completed correctly that day.

However, when we audited a sample of people's medicines we found there had been an error with one person's medicine. We spoke to the team leader about this and they checked the MAR chart, they could not account for this error.

Some people were at risk of developing a breakdown in their skin due to their limited mobility. These people were prescribed creams to try and prevent this. We looked at people's records and found some gaps in the

recording of the administration of this type of medicine. Therefore it was difficult to know if these people had received this medicine as the prescriber had intended.

Requires Improvement

Is the service effective?

Our findings

The staff we spoke with felt they had the skills and knowledge to be effective in their work. The manager told us that new members of staff had an induction which consisted of computer based training and shadowing experienced staff. The decision that a new member of staff was ready to work alone would be made by the experienced member of staff who they shadowed. However, there was no competency test to ensure new members of staff were ready and able to work independently.

When we asked staff about their knowledge of people's needs who lived at the home we had a varied response from staff. Some staff were able to tell us what individual people's needs were and how they supported them to meet these needs. However, some of the staff we spoke with were unable to do this.

Staff told us what training they had completed recently. We were shown a training plan for the year which stated staff training was up to date. Staff received training in fire safety, moving and handling, food hygiene, safeguarding, and health and safety. New members of staff were placed on the 'care certificate' course; this is a set of standards outlining what good care looks like. However, some staff told us they had not had training in dementia care or in managing and preventing people's skin from breaking down.

Some of the staff we spoke with told us that some shifts worked better than others due to the staff who were working on a particular shift. One member of staff said, "You can have a difficult shift depending who is on." We spoke with the manager about supervisions and assessing staff knowledge and competency. The manager told us that supervisions had not taken place for some time in the home. However, they showed us some appraisals which had been recently completed. The manager told us they relied on staff sharing their concerns about staff competencies with them. We were told of a recent example of this and were shown the action the manager took to address this issue.

We asked people who lived at Sunnycroft about how staff communicated with them. One person said, "They can't understand me and I can't understand what they're saying." A different person's relative told us, "[Name] does have a problem understanding some staff from other countries." Another relative said, "The biggest problem is the language barrier with staff."

On the day of our visit we observed staff communicating clearly and professionally with one another and with the people who lived in the home. The manager told us they recognised there was an issue with the communication of some staff who worked in the home. The manager was unable to tell us of plans or any processes in place to address this issue.

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 application 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had identified people who may be deprived of their liberty and had made applications for authorisation to ensure that people's rights were protected. The service continued to ensure that people were not restricted more than was necessary to keep the person safe.

The manager and most of the staff we spoke with had a good understanding about mental capacity and promoting people's choices. One member of staff told us, "I always look over the fact they may be living with dementia, I always offer choice." Staff told us how they offered choice with meals and drinks. We observed staff asking people if they wanted to join in the activities, where they wanted to sit, and what they wanted to eat and drink.

We spoke to people about their views on the food. We had mixed views on this subject. One person said, "I think they're very good quality (meals), yes, there's enough choice." Another person told us, "On the whole the food is very nice." However, one person told us, "It's gone down a lot recently, you don't get so much variety, and the choice is virtually the same every week." A further person said, "I don't like big meals, I prefer little and often." Their relative added, "Big platefuls are off putting."

We observed lunch and found people were offered and had a variety of different meals and drinks. Some people made positive comments when they ate their meals. One person was not eating their meal; a member of staff came and spoke with the person, and then suggested a different meal. We later saw this being offered to the person and saw them eating their meal.

Some people were at risk of developing a breakdown in their skin or at risk of dehydration. There were plans in people's room to manage these needs. We could see that staff had followed these plans. We also found staff totalled what amount of fluids people had had. However, we found no rationale as to why this volume was required and what action staff should take, if the person had not had that volume that day.

People told us they had contact with health professionals when they needed to. One person said, "The doctor came to see me today, I only asked for him last night." Another person said, "Oh yes, doctor, promptly." During our visit we saw two different doctors and a nurse practitioner who were visiting people in the home. The home had a weekly visit from a doctor and additional visits if staff identified health concerns. We spoke with a visiting health professional who felt the home responded positively to a change in people's health needs.

Good

Is the service caring?

Our findings

The people who lived in Sunnycroft were treated in a kind and caring way. One person told us, "People are kind and they talk to me about my symptoms." Another person told us, "Everybody is quite friendly." One person's family member told us, "Staff go out of their way to come and visit [Name]."

Many of the people who lived at the home were living with dementia and often became distressed and anxious. We observed staff offering support when people became distressed. Staff would try and re-assure the person. We saw staff speak gently with people, place their hands on their shoulders in a caring way, and they talked to them at their eye level. A relative told us, "They're always happy, bubbly, a bright greeting, very friendly; I've never seen any of them not being positive, even under duress from residents."

Staff told us how they offered people choices in order to involve people in their daily care needs. We looked at people's care records and we could see that initially people and their relatives had been consulted with about their care. We observed a member of staff explaining to people what their medicines were for and why the GP had prescribed them. We saw a member of staff ask one person how they wanted to take a particular medicine. We heard some staff explaining to people what the activities were that day, in order to see if people wanted to take part.

People were supported to maintain relationships with people who were important to them. We looked at people's care records and we could see the service had identified who those people were. Some of the staff had a good knowledge of who people's relatives were. We heard them referring to them when they spoke with particular people who lived at the home. The relatives we spoke with said they felt welcomed in the home. One relative told us, "You always get a friendly greeting on arrival, welcoming, I know people here are always approachable, you can visit anytime, the general impression is positive."

On the day of our visit we found people's information was stored securely and treated in a confidential manner. People's care records were stored securely in a filing cupboard. Staff spoke discreetly with one another when supporting individuals. We observed a hand over meeting between members of staff. This was conducted in a closed room and staff spoke about people in a respectful way.

The staff we spoke with told us how they promoted people's dignity. Staff explained to us how they did this when providing personal care to people. We observed one member of staff support one person from the lounge to their room, in order to administer one of their medicines to them. Staff also told us how they protected people's privacy. We observed staff knocking on people's doors and saying who they were. We saw one member of staff assist one person to the bathroom, we saw them wait outside the bathroom and later we saw them knocking on the door to enter.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care which was responsive to their needs. A relative told us, "[Name] can't have the commode between twelve and one thirty, they [staff] have said there isn't anyone available, people being fed." This relative told us how their relative became distressed at this time most days.

Some people told us that staff did not have enough time to support them with tasks which were in additional to their daily personal care needs. One person had had a stroke, they told us staff did not assist them with improving their speech, they told us this frustrated them. Another person said, "The physio said I must walk a little further each day, the problem is time, and everyone is so busy."

Some people who were living with dementia were very anxious and were often visiting the reception area saying they wanted to go out or thought their relative was collecting them. The manager told us that they and the office staff were spending a lot of their time responding to these people's needs and were unable to complete their other tasks. As a result the manager had a secure door fitted to stop people coming into the reception area. The manager said, "It sounds awful but we had no choice." We saw some people repeatedly come to the door and ask to come through to the reception area. On some occasions people became distressed and banged on the door. The manager and provider had not considered other additional ways to meet these people's needs.

People didn't feel staff had the time to chat and spend time with them. One person said, "They [staff] haven't got time to come and talk to me." Another person said, "I don't think they [staff] have time to sit down and talk to people."

The manager and some members of staff told us that they didn't feel there were enough staff to meet people's emotional and social needs. These members of staff didn't feel there were enough staff to sit and talk with people. Staff told us they tried to do this when they provided personal care to people, but they were not able to meet this need throughout the day. One person told us, "I don't see anybody now (after lunch), after a while it gets a bit wearing."

During our visit we didn't see any staff spending time talking with people or engage with one to one activities. We observed some staff supporting people to eat and drink. However, in these interactions we saw that staff were not communicative with these people.

The above concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at some people's care records. We could see that when people first entered the home at their initial assessment people had been asked about their backgrounds, the people who were important to them, what their likes and dislikes were. However, we often found that people's needs were not recorded in a person centred way. Some parts of people's care assessments were written in a generic way, we found examples of typed assessments with gaps where a member of staff had written 'she' or 'he' to make it

relevant to the person. One person's assessment originally made reference to the person living in the provider's other home, someone had drawn lines through this and written Sunnycroft above it.

People's assessments did not take into account their mental wellbeing. They gave details about people's mental capacity which was a list of statements with a tick next to some of the statements. However, they did not consider people's emotional needs. We observed that some people were distressed on a regular basis throughout our visit. Staff comforted these people but there was no planning or re-assessment of these people's needs, to see if additional support is needed. Or to consider if all staff had the knowledge, skills, and time to meet these people's needs.

We found that people's reviews were not meaningful or robust. We looked at one person's needs that had changed significantly since they first moved to the home. We found staff had written each month "No change" on various risk assessments. However we could see their needs had changed. For example it stated the person's mobility needs had not changed, when the person moved to the home they were mobile with a frame, they were now unable to mobilise independently. We found other examples of this in this person's care records.

When we looked at other people's reviews and assessments we found that staff had not involved the person or their relatives in people's reviews. We spoke with the manager about people's care assessments. They told us they had identified they were not robust enough and they intended to rectify this.

When we spoke with people about the choices they made regarding their daily lives, they gave us mixed views. One person said, "They come round and ask you what you want (to eat) for tomorrow, they come and ask you before lunch for the next day." A relative told us, "They asked [relative] if they wanted a bath or a shower." However, we spoke with one person who told us they were not offered a choice with what they wanted to eat and when they got up in the morning. They said, "If you're lucky it is 06:30 am, I would like 07:30 am."

The manager had recently employed three members of staff who supported people with activities. During the two days of our inspection we observed that one activities coordinator was working on shift. We saw two activities taking place, bingo and a Christmas craft. Two people told us they had enjoyed the activities. We could see from photos on the wall there had been planned outings this year. The manager told us that they hoped this new system would meet people's social needs.

However, some people told us the activities did not interest them. One person said, "I don't join in, I don't want to, it's a very older place here." Another person said, "No one can really participate in conversation and activities, there is no one here who could share a game with me."

Relatives told us they felt they could approach the manager and raise a complaint. We were shown a complaint that a relative had made about the care their relative received. We could see the manager had conducted an investigation and checked the home's records and spoke with staff.

Requires Improvement

Is the service well-led?

Our findings

There were insufficient audits taking place from the manager and the provider to ensure people who lived in Sunnycroft were safe and to monitor the quality of the service provided.

We were told there was no full auditing of people's administration of their medicines. During our visit we found some issues with the administration, storage, and recording of the administration of some people's medicines. Without regular auditing of the safe administration of people's medicines errors and further risks could develop.

There were insufficient numbers of staff to respond to people's emotional needs. The manager and provider had not completed an assessment of whether there were enough staff with the right skill mix to meet people's changing needs.

There were no robust systems in place to monitor the quality of staff practice. It relied on staff independently addressing concerns with the manager. The manager told us about one member of staff who sought advice from the manager, which had inadvertently highlighted their lack of knowledge and understanding about a particular issue. The manager said they spoke about this issue but no further training was provided. Supervisions had not taken place for some time. There was a lack of monitoring and assessment of new staff to see they had the skills to perform well in their work.

The manager was aware people's care records were not person centred and needed further development. However, there was no robust plan in place to address this issue. The manager told us about a plan for team leaders to be taken away from delivering care so they can focus on the care records and supervisions. However, there were no robust plans in place in order to support this system to work. No plans had been made regarding training these members of staff to support them to perform well in this role.

People's care was not reviewed in a meaningful way which had considered the changes in their health and emotional needs. The manager and the provider were not aware of this until we had identified this issue. People were not consulted with or asked about their views of the home. One person said, "I haven't been asked about my views, and there's no meetings." Another person told us, "I've not had a conversation like this with anyone since I've been here." The person added they had been at the home for two years.

Many people at the home were living with dementia. There were no robust systems to support and address a change in a person's mental wellbeing. Some staff had had training in dementia care but there was no specialist knowledge or lead within the service.

Staff were living on site and had access to the home day and night. The manager and provider had not competed a risk assessment to ensure that people who lived at the home were protected against this potential risk. There were also no emergency plans in place to support staff to respond to emergencies with confidence.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of the service had changed since the last inspection. The previous provider is now a director of a new limited company. The service's registration had changed; they were no longer providing nursing care.

There was also a new manager who had been in post since August 2016. The manager told us that they were still assessing the service and considering how the service needed to improve. They told us they were motivated to make positive changes and to, "Improve the reputation of the home."

There was a positive and friendly atmosphere at the home. Most staff knew people and reacted in a caring and thoughtful way to people. Staff took people's distress seriously and responded in a compassionate way.

People and their family members spoke positively about the manager and the home. One person said, "I feel that I can speak to [the manager]." A person's relative told us, "I can't think of anything I go home worried about. I'm really happy generally with everything they're doing."

The staff we spoke with told us they had confidence in the new manager. One member of staff said that the manager is, "Firm but fair." Another member of staff said, "[Manager] is getting a good team together." Staff told us the manager is present and involved in the home on a daily basis. We observed the manager talking to relatives and people who lived at the home.

Some safety checks had been taking place for example testing water temperatures in people's rooms to prevent people from being scolded. However, the manager had questioned how accurate these had been in the past and made changes to ensure accurate testing took place. Various tests took place to ensure the premises were safe.

We were told about improvements to the decoration of the home and rooms were being refurbished. In these rooms we could see there had been a real effort made to improve the environment for the people who lived in these rooms.

The manager had made a plan for a relatives meeting the same month we visited. The manager told us that this was an effort to involve people's families in improving the service for their relatives. The manager had also considered how to involve the local community with the home, but no firm plans had been made.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (RA) Regulations 2014: Person-centred care. The service had failed to protect people against risks by doing all that is practicable to mitigate any such risks Regulation 9 (1) (b) (c) 3 (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe care and treatment The service had failed to protect people against risks by doing all that is practicable to mitigate any such risks. Regulation 12 (2) (a) (b) (c) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided.

Regulation 17 (2) (a) (b) (c) and (e)