Libury Hall

Libury Hall

Inspection report

Libury Hall
Great Munden
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Tel: 01920438224

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Libury Hall is registered to provide residential care for up 37 older people living with mental health needs. At the time of our inspection 36 people were living at Libury Hall.

The inspection took place on 09 November 2015 and was unannounced which meant the provider did not know we were inspecting. We previously inspected Libury Hall on 13 November 2013. During that inspection we found that the provider was meeting the requirements.

The home had a registered manager in post who had been registered since July 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At this inspection we found sufficient numbers of staff were deployed to provide care safely to people living in Libury Hall. The registered manager had not made arrangements to review and investigate incidents and accidents to keep people safe from the risk of harm or abuse. Risk assessments had not always been developed to positively manage risks to people and where risks were identified staff minimised the importance of these. People's medicines were not always stored safely and information was not always available to staff about how to manage medicines. People were supported by staff who had undergone a robust recruitment process to ensure they were of sufficiently good character to provide care to people.

Staff felt supported by the manager and provider to enable them to carry out their role sufficiently. Staff had received training relevant to their role, however we found new staff with no previous experience in mental health services had not received the required training prior to supporting people alone.

People's nutritional needs were met and monitored. People were able to freely choose what they ate and people's weights and dietary records had been maintained. People we spoke with told us they had access to a range of health professionals, and records demonstrated they were referred quickly when their needs changed, which was confirmed by visiting professionals.

Staff spoke to people in a kind, patient and friendly way and people were treated in a dignified manner. Staff consistently ensured people's social needs were met, however people did not always receive care that was responsive to their needs.

Libury Hall promoted a culture that was open and honest, staff morale was high and people felt the provider was approachable. However people also felt the registered manager was not visible within the home. People did not receive high quality care that was well led and regularly monitored. People's personal care records were not regularly reviewed, completed or updated when required.

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 safe.

Risk assessments had not been completed to safely manage identified risks of harm to people or others.

Where people were at risk of harm, the manager had not sufficiently investigated and reviewed incidents to ensure people were kept safe.

There were sufficient numbers of staff deployed to support people's needs.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were able to access a range of healthcare professionals when their needs changed, however communication meant that staff were not always aware of the circumstances or background when referring.

Staff had been supported by the manager or provider to enable them to carry out their role sufficiently. However, key specific training required for staff to safely carry out their role unsupervised had not been provided.

Staff gained people's consent prior to assisting them with tasks.

Assessments of capacity had been carried out in line with the requirements of the Mental Capacity Act 2005 and people were not unlawfully deprived of their liberty.

People were supported to eat or drink sufficient amounts.

Is the service caring?

Requires Improvement

The service was not always caring

People were not always able to influence or contribute to their

care, and were not always kept up to date with developments.

Staff spoke with people in a kind and sensitive manner and ensured people were treated with dignity.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive care that was responsive to their needs.

People's wellbeing was not always supported by staff as they failed to ensure that their individual needs were monitored and met safely.

Care plans were person centred and included areas around people's likes, dislikes and interests.

Is the service well-led?

Requires Improvement

The service was not well led.

People told us that the provider was approachable and listened to their views. However people also felt the registered manager was not visible in the home.

Systems of processes were not effectively established to ensure people receive a safe and high quality service.

People's care records did not contain sufficient information to reliably inform staff. Reviews of peoples care needs were also insufficient.

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Detailed findings

Background to this inspection

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

This inspection took place on 08 November 2015 and was unannounced. The inspection team consisted of one inspector, a pharmacist inspector and a specialist advisor whose area of expertise was as a nurse advisor in psychiatric care.

Prior to the inspection we received information of concern that suggested people were not cared for in a safe manner. We also reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we observed staff support people who used the service, we spoke with 14 people who used the service, eight members of staff, the provider and deputy manager, two visiting health professionals and a member of the contracts monitoring team for the local authority. We spoke with four relatives to obtain their feedback on how people were supported to live their lives.

We reviewed care records relating to seven people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires Improvement

Is the service safe?

Our findings

Incidents and accidents that took place were not consistently managed. We reviewed the incidents log and noted that some incidents identified in people's daily records had not been reported to the manager. For example in one person's daily records staff had noted they had suffered from frequent falls. A number of these falls had not been reported, and the care plan for this person had not been reviewed in response to this. We asked how incidents were reviewed and monitored to identify trends or patterns and were told by the deputy manager that they were not. This meant that people were not always protected from harm or unsafe treatment because a system of reporting, reviewing and identifying risks to people was not robust or consistent.

We spoke with the provider about the inconsistencies in incident reporting and investigating. They told us they were aware that the systems required reviewing and were in the process of addressing this with the manager.

Staff had assessed, but not always documented effectively through care planning, matters that mitigated risk to people or others. One person had a history of sexualised behaviour towards others. We saw that this had been identified at the assessment stage, however, care plans relating to this specific behavioural issue had not been developed. Some staff we spoke with were unaware of the risk that this person presented to others, and those who were aware did not appear to fully appreciate the risk that this posed. One staff member we asked about how they monitored and managed this told us, "Oh they are old now and we try not to talk about it."

We also saw for a second person who had displayed aggressive and violent behaviour towards another on numerous occasions, the manager had not ensured an assessment and review of their care needs was carried out. They had referred the matter to the local authority for review, however had not considered how to effectively manage the behaviour in the interim period. Care planning had not effectively identified and mitigated the risk to the person and others, and staff were not all aware of how to manage this consistently. For example, one staff member we spoke with told us that some staff removed the person being aggressive, and others told us they removed the person who was being struck. There was no clear plan in place that was understood by all staff about how to consistently manage the incidents, and also about how to identify the triggers that may precede the behaviour. This meant that effective systems were not in place to identify and manage behaviours that placed the person or others at risk of unsafe care or treatment.

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

People we spoke with told us they felt safe living at Libury Hall. They commented that they had known the staff for a long time and felt comfortable in the company. One person said, "Oh yes, very safe and very happy." One person's relative said, "That's the nice thing about Libury Hall, I don't have to worry about how [person] is. They are cared for and that gives me peace of mind."

Staff we spoke with were able to describe to us what constituted abuse and what signs they looked for when supporting people. There was a range of information available to people, staff and visitors informing them how to report their concerns. Information for external agencies such as CQC or the local authority were prominently displayed where people could also raise their concerns. Staff we spoke with were aware they could report their concerns to both the local authority and CQC and were clear about their responsibilities around whistleblowing. Staff spoken with had no hesitation in telling us they would immediately report any incident or conduct they felt was abusive. One staff member told us, "Anything that I think affects their wellbeing I will document and report to my manager."

People told us there were sufficient numbers of staff available to provide their care and support, and these views were shared by the staff we spoke with. One person said, "There are lots of staff to help me when I want them." One staff member we spoke with told us, "Yes I think we have enough staff to do what we need to now." One person's relative told us, "Yes, it's better lately, it hasn't always been this way, especially with the activity, but recently it has got better." The provider told us they had recently recruited additional staff over the previous three months. They said that in addition to support workers, they had also recruited a further two activity staff so they could further meet people's social needs. The provider demonstrated to us how they were able to be flexible with staffing when people's needs changed. For example, when people were sent to hospital for a short term admission staff were able to support them both whilst at hospital and on their return to Libury Hall if their needs required this.

Medicines were not always stored, managed or administered in a safe manner. We found there were gaps in the recording of the temperatures that medicines were stored at, and there was no record of the maximum or minimum temperatures maintained. Where people had been prescribed medicines that required monitoring we were unable to see where this had been carried out. Best practise guidelines would be for people's blood tests and resulting change in prescription to be recorded in a yellow book for warfarin for example. A second person had been prescribed an antipsychotic medicine. Guidance states that this person was required to have monthly monitoring of their blood to ensure they did not encounter suffer from a further blood disorder. The last recorded test for this person was in February 2015. No accompanying plan was available to direct staff to the frequency of monitoring for this person. As we looked in people's MAR's we found that a third person had been prescribed a sedative to manage their mood recently. However there was no documented regime of how to administer this medicine to the person. Staff told us that the information was available in other records, however, we looked in people's accompanying care plans and daily records and were unable to ascertain how the above people's medicines were managed. We asked to see if the information may be elsewhere, however no further documentation was produced.

Mar record's had been completed when medicines were administered. We observed one member of staff during the medicines round, and saw they took their time to administer them, and also offered people the opportunity to go to a side room to have their medicine to protect their privacy. However, we also saw that additions to people's medicines had been entered manually into the MAR by staff handwriting the change or new medicine into the record. These had not been counter signed by a second staff member to ensure they were accurate. This may lead to a risk of the incorrect dosage or medicine being entered and inadvertently administered to people.

The GP visited fortnightly and had recently increased this to weekly due to the winter weather. They carried out a review of people's medicines on a monthly basis which mitigated some of the risk of staff not effectively completing medicine care plans and assessments. Audits of medicines had been carried out monthly by members of the senior team, and where issues had been identified these had been rectified and notes had been made in relation to medication errors. However, the auditing had not proved effective as the issues identified at inspection had not been picked up through this process.

Requires Improvement

Is the service effective?

Our findings

People we spoke with felt the staff were sufficiently trained and well supported to perform their roles. One person told us, "Very good, very well trained." One person's relative told us, "The staff really know what they are doing and [relative] can be very difficult sometimes and they manage [relative] well." One visiting health professional told us, "Staff are well trained, I've never seen anything that gives me cause for concern, the attitude is excellent."

Staff told us they received regular training updates, and met with their line manager frequently to discuss their performance and provide support where needed. Staff told us they underwent an induction when they started working at Libury Hall which included face to face training in areas such as safeguarding and moving and handling, and also shadowed an experienced staff member. They told us they were then only able to provide support to people on their own once they were assessed as being competent. One staff member told us, "Induction was intense, but really helped me to feel comfortable working here, there was lots of different training and I was watched to make sure I was able to care to the standard they expect." However, newly recruited staff we spoke with did not have experience of supporting people with mental health needs, and had not undergone training prior to supporting people alone. When we spoke with staff about their understanding of a person's diagnosis or mental health background they were unable to tell us. One staff member told us, "I am fairly new to mental health care, with not a lot of experience in mental health, having worked with challenging behaviour in the past. I have done some basic training since working here including moving and handling, challenging behaviour and applied for level 2 in health and social care. I do not know all the residents here." This demonstrated that training had not always sufficiently equipped new staff to understand the needs of people they supported.

We observed that before staff provided support or assistance to people they explained what they wanted to assist the person with and waited until they gave their consent. We saw that staff attempted on several occasions to encourage a person to have a wash and change their clothes. They refused a number of times, however staff respected this wish, and then returned later to ask again if they were ready. Eventually the person agreed, and took themselves off to their room for assistance. This showed us that staff took the time necessary to explain what they needed to do, but waited until the person was ready to provide their consent.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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 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 in line with the principles of the MCA. At the time of our inspection, no people living at Libury Hall were considered to lack capacity. Staff we spoke with were aware of their responsibilities towards assessing and supporting people who may lack capacity and had received training to support this. One staff member we spoke with told us, "Nobody here has capacity issues, but even if they did, it doesn't change how we care for them and put their needs first." There were no instances where people were deprived of their liberty or restrained in any way, people were free to come and go as they pleased, and staff understood their responsibilities around restraining or depriving people of their liberty.

People told us they enjoyed the food provided for them, and there was always plenty to eat, with a range of healthy snacks available.. Food was freshly prepared and alternative options could be provided if people chose to not eat the main meal. People did however tell us that a cooked breakfast was only available on a Saturday and they would at times, like to have the option of a hot breakfast when they felt like having one.

The dining area was sociable, although in many places was tired and in need of redecoration as the environment felt institutional and lacked a homely feel to it. Staff were observed throughout the breakfast and lunch sittings, to assist people who required this, and prompt people for further helpings who either finished their meal or who said they were not particularly hungry. Once people were settled, staff then sat with them at the table and ate their own meal. People responded positively to staff sitting with them, and we saw that not only were staff able to then have meaningful conversations, they were also able to support people in a more casual and relaxed manner. One person who was not eating well when lunch was served, was then seen to eat well when staff sat with them and finished a meal they may not have done if staff did not sit with them and talk socially.

People who were at risk of weight loss were regularly monitored, and where their weight dipped slightly staff referred them to the appropriate professional. Where people were at risk of developing pressure sores we saw the appropriate equipment had been obtained and was used. We spoke with a visiting health professional who visited the home most days. They told us, "The staff are pretty clued up here, they let us know straight away about any skin conditions and they are always keen to learn new things from me."

People and their relatives told us that if a person's health deteriorated then they were referred quickly for support. Records we looked at demonstrated that a range of health professionals were involved in people's care including GP's, district nurses, community psychiatric nurses, mental health crisis teams, dentists, opticians and dieticians where needed. One GP told us they enjoyed visiting Libury Hall and that they thought people living there were well cared for and looked after. However they also told us that staff lacked confidence and err on the side of caution in asking the GP to see residents. They told us they felt some staff were not aware of the basic information they needed to report such as how long a person had a cough, if they had maintained their appetite or if they had a temperature. They said that staff would often say they didn't know as they weren't on duty when the appointment was made and no record was available to corroborate the reason for the appointments being made.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated with kindness and compassion by staff. One person told us, "Staff are friendly and supportive. All staff know my name and treat me with dignity and respect." One person's relative told us, "It's like a family home from home there, so many of the staff and residents have been together for so long that they feel it is their home."

Staff had developed positive relationships with people, we saw constantly through our inspection that staff and people shared smiles, jokes, conversation and discussed shared interests that engaged people positively. People looked to be comfortable and at ease with the staff which promoted a relaxed and comfortable atmosphere within the home.

People and their relatives told us staff treated them in a dignified manner and respected their privacy. One person told us, "They [staff] will leave me alone when I want, or sit with me when I need them to. They don't make me feel awkward or embarrassed, I think they are brilliant." We observed throughout the inspection that when people required assistance, staff approached them in a sensitive manner, and quietly escorted them to assist them. When staff entered people's rooms or bungalows, they knocked and waited for the person to respond. This helped to ensure that people's dignity was maintained.

We saw that staff responded positively to people who were distressed. One person had clearly was upset and agitated on the day of our inspection. Staff were observed to spend time with this person, and demonstrated a patient and caring attitude towards them. They constantly spent time with them, spoke to them warmly and attempted to distract them with activities and discussion. Gradually throughout the day, the person's mood levelled and their agitation abated. When we left at the end of the day, this person was asleep in the lounge.

People told us they were able to make choices about the way they spent their day. We observed people throughout the day coming and going to the day centre to undertake activities, or spend time alone reading, painting and other activities. However, people also told us that staff did not always keep them well informed about their care. One person told us that they had not sat down with their keyworker to discuss their care needs for over two months, where this should be monthly. They told us they did not know what their eventual plan of care would be, or how they would achieve their goals. They told us, "I don't know how long I am here for, or if I can go home or when, I ask the staff but they never give me an answer."

People and their relatives told us they were able to visit freely at any time without restrictions placed on them. Staff supported people to visit relatives where transport was difficult, and regularly took people on day trips to see loved ones. One person's relative told us, "Come and go as we want to, we don't need to book we just turn up and go out for the day when we like."

One person's relative told us that staff were usually very good at keeping them informed about their relatives care, however had grown frustrated over recent weeks due to a lack of communication. They said that their relative had gone for an x-ray due to long standing health concerns; however staff had not

informed them of the outcome. This relative was concerned at not knowing the outcome, but told us, "I don't want to be a burden so will just wait for the staff to tell me." This demonstrated to us that the approach to ensuring people were involved in making decisions and planning their own care was inconsistent, and that people were not always kept informed or consulted.

Requires Improvement

Is the service responsive?

Our findings

Care plans we looked at relating to personal care matters and social activity were person centred in that they had information regarding likes and dislikes activities of daily living, for example washing, bathing, eating, drinking, sleeping, and mobility. The care plans when completed documented how the person wished to receive support for each of these identified areas.

However care plans relating to physical and mental health matters were basic with no substantial information on mental and physical health problems, medical history, and diagnosis, medication management, or evidence of interventions. For example, where people displayed behaviour that challenged, or who were prone to suffer low mood, their views had not been sought on how to manage this. Care plans did not always provide guidance for staff about how to respond to people's identified support needs in a person centred manner that was led by the person's views and opinions.

For example, one person who displayed repeated aggressive behaviour towards others did not have an assessment of plan of how to manage this. Staff had not sought to understand the person's life history or experiences to understand if anything may trigger an episode. Staff were not aware of the person's history, or how to spot any triggers, and did not explain to us a consistent method they used to intervene and distract the person when they were upset.

The provider and deputy manager told us that they were currently undergoing significant changes at Libury Hall. They told us that previously people could expect to live at the home for life. However, they told us that a significant change in providing care to people placed an emphasis on them to be independent with a focus on returning to the community, if they are assessed as being stable.

However, we noted that for people who were living independently in the adjacent bungalows, staff had not thought to encourage them to manage their own medicines or their own meals for example. People were living in the bungalows because they had demonstrated an ability to live without the constant support and supervision of staff in the main house, however, care planning did not reflect this change, merely the fact the person had moved.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received the care they required when they needed it, and that they had choice and control about their daily lives. One person told us, "I have been here 11 years it is my home. I like it here very much, staff support me and take me out shopping. Staff are kind and friendly towards me. I like the activity centre it gives me something to do during the day. I enjoy singing and social activities."

People were encouraged to engage in activities, and develop their social skills to avoid isolation. The home had a dedicated day centre that people freely accessed throughout the day. There was a heavy focus on social inclusion and the opportunity to follow individual interests. People were seen to be playing games,

cooking a meal for themselves and a friend, drawing, listening to music, reading and talking to one another. The provider had recently recruited two activity staff who were in post to further develop the day centre, to ensure that people in the home who chose to not attend the centre were not isolated.

Wherever possible, staff actively encouraged people to assist in the running of the home, particularly at meal times. One person told us, "I have been here four years and I love it here at Libury Hall. Staff are kind and friendly they let me help with chores like laying the tables for dinner. I enjoy going to the activity centre and going out with staff shopping. Staff are always kind to me and respect me. Staff know my likes and dislikes." One person who had sight difficulties was regularly supported by staff in the main house because they did not want to attend the day centre. Staff told us they regularly spent time with this person talking, painting their nails, listening to talking books and playing classical music.

People who lived at Libury Hall were encouraged to be an active part of the wider community. Each day people were able to go to the village shop, and also on outings to local towns. Information was available in the home for people to access college courses if they so wished, and also for responsibilities in the home that enabled them to develop skills. One person told us they were able to help with the gardening around the home, and took pride in showing us their work. They said, "It's good for me, it gives me something to do and it's nice to grow our own veg."

People were not isolated, and staff went to great lengths to ensure people were both not alone, and also had frequent contact with their families. One person's relative told us, "They go the extra mile. We can't drive down there much now, so the staff bring [People] all the way up here to us so we can go out and have a meal." A second relative told us, "We can come and go whenever we want to see [person] and they are able to visit whenever they want and phone us regularly."

People told us they were aware of how to make a complaint if they were not happy. One person said, "I go to [Provider] if I am not happy and they make it right." Information was provided to people and visitors about how to complain, and if they are unhappy with the outcome then the details of external organisations was provided. We looked at how complaints were managed by the manager. Where complaints or concerns were raised, these had been reviewed and responded to. People and their relatives told us that they were confident that any concerns they raised would be dealt with appropriately.

Requires Improvement

Is the service well-led?

Our findings

The manager had systems in place to audit the quality of care people received. These included areas such as medicines, care planning, health and safety, and staff training. However, we found that these audits were not always effective, and where issues were identified, they had not been rectified in a reasonable time frame. For example, the local authority's monitoring team had visited Libury Hall in May 2015. As a result of this visit the home had achieved an overall score of 74% indicating at that time the home was considered to be requiring improvement. Actions that arose from this visit included a new format of care planning to be implemented for the 36 people living there, and accurate completion of daily records. An action plan submitted by the manager did not identify when these areas would be completed by, and at this inspection we found the improvements had not been made. Where the management team had carried out their own audits of the quality of service provided, they had not identified or addressed concerns we found at this inspection in care planning, risk assessments, medicines management, or incident monitoring and review.

The provider or manager did not have a service improvement plan available that identified, addressed and remedied concerns, such as incomplete care plans. This demonstrated there was not a robust and systematic method of reviewing, assessing and responding to concerns that may affect the quality of service provided to people.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Records were incomplete, with a variety of care plans missing from peoples files that were pertinent to their care. Daily records and observations of people throughout the day were not clear as the daily entries in case notes were not always recorded. Incident reports that were completed did not contain sufficient information to demonstrate how the incident happened and how the risk would be mitigated in the future. This meant an accurate record of a person's care and treatment had not been maintained.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People we spoke with told us they felt the management team were approachable and visible. One person told us, "[Provider] is amazing, I like seeing [Provider] around the home because they get things done." One person's relative told us, "[Provider] will always call and have a chat through things if I want them to, but I'm not sure who the manager is."

A theme of the inspection was that people and relatives did not feel the registered manager was visible. Some people were not aware the provider had recently stepped away from the manager's role, and continued to refer to them as the manager. However, the service did have a registered manager in post who had been registered with the Care Quality Commission since July 2015. We spoke with the provider about this lack of visibility and they told us they were aware of this and were looking at ways to ensure the

management team had a greater presence.

The provider told us that they operated an 'open door' policy and frequently met with family members to explore any concerns or compliments they had about the service provision. Relatives we spoke with told us that they were regularly asked to complete surveys and questionnaires about the quality of the service provided, and felt able to raise any issues with the provider.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not reflect the needs and preferences of people and had not been completed collaboratively with the person who used the service. Regulation 9 (1) (a) (b) (c) 3 (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that is reasonably practicable to mitigate the risks to service users by ensuring identified risks were effectively assessed and managed. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not operated effectively to assess, monitor and improve the quality of service people received. An accurate and contemporaneous record of a person's care and treatment had not been maintained. Regulation 17 (1) (2) (a) (b) (c)