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Ascot Villa Care Home For Autism & LD

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Ascot Villa Care Home on 9 and 10 November 2017. This inspection was to check that improvements to meet legal requirements planned by the provider after our 16 August 2017 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service Well Led, Safe and Responsive. This was because the service was not meeting four legal requirements.

During this inspection we found that the provider had met one legal requirement in relation to recruiting staff safely. However the three other legal requirements we told the provider to meet during our last inspection had not been met. These related to areas of safety of people, how person centred the service was and how well it was governed and managed.

Ascot Villa 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. Ascot Villa is a care home without nursing that can accommodate up to six people with learning disabilities and autism. At the time of our inspection four people were living at Ascot Villa.

We undertook this focussed inspection to check on progress that had been made since our last inspection in August 2017. At that time the service required improvement in three key areas and had been rated as inadequate in the key areas of Safe and Well Led.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our on-going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Ascot Villa did not have a registered manager in post when we inspected. The provider made an acting manager available to us throughout our inspection.

People and relatives said they felt the service was safe. Staff understood general risks to people's health and safety. However risks that were specific to individuals were not always known about by staff. Recording of these risks was not always evident, and in other cases had not been kept up to date. There were sufficient staff to meet people's needs. The provider operated a safe recruitment system which meant people were supported by suitable staff. Staff understood their responsibility to raise concerns regarding potential abuse.

Staff did not all have the training they needed to undertake their roles safely and appropriately. Staff understood the need to ask for consent and we saw that they asked people before providing any care. People's nutritional needs were being met, and the provider had started to introduce more choice into the menu. People had access to health professionals when their health needs changed, however we were not confident that all healthcare needs were well met.

Medicines management had improved since our last inspection but there remained some areas of concern relating to medicines that were in boxes and an ineffective auditing process. Some areas of infection control were poor and related to damaged furniture and fittings within the home. Food hygiene had improved.

People had not been involved in planning or reviewing their care. People received care which was not always responsive to their individual needs. Improvements were required to ensure people's care records contained up to date and accurate information about the care they received. People and their relatives told us they felt comfortable raising complaints with the manager and they said they felt they would be listened to.

The governance system had not been implemented at the time of our inspection, and there had been no improvement of quality or actions taken by the provider to mitigate risks. There were very few audits of the service and those that did take place were not effective.

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, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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

During this inspection we found that provider remained in breach of three regulations.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

People were not kept from harm as staff did not always know what to do to keep them safe.

Medicines were not all administered safely and the auditing process of administering medication was ineffective.

People were supported by sufficient numbers of staff.

Staff were recruited safely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive care and treatment that met their needs or preferences.

People were not supported to communicate in a way that was appropriate for them.

People were not involved in their care and support other than in smaller day to day matters.

People knew they could complain but the process to do so was not accessible to them.

Is the service well-led?

Inadequate

The service was not well led.

Effective Systems and processes had not been established to assess, monitor and improve quality and safety.

Records were not complete, accurate or contemporaneous.

Feedback from people and others had not been sought.

Ascot Villa Care Home For Autism & LD

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 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 site visit activity started on 9 November 2017 and ended on 10 November 2017. It included conversations with people, the manager, and staff. We made observations to see what peoples experience of their care was. People showed us their rooms and we looked at records, including peoples' care records and other information kept by the provider. We pathway tracked two people which means we looked in detail at their care and if their records reflected that care accurately.

The inspection team consisted of one inspector. After the inspection an Expert by Experience made phone calls to the relatives of people to gain their views. 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 expert had experience of supporting people with learning disabilities.

We asked the provider to complete 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. This was received within the necessary timescale. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We refer to these as notifications. We reviewed the notifications the provider had sent us and in addition considered feedback provided to us by commissioners of the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan what areas we were going to focus on during our inspection visit.

We spoke with one person who lived at the service and spent time with three other people in communal areas and in their rooms by their invitation. We spoke at length to three members of care staff, and one health care professional who has regular contact with the service. We also spent time with the acting manager. The expert by experience spoke with two relatives.

After the inspection we asked the provider to send us some information relating to the training and learning of the staff which was sent to us in a timely manner.

Inadequate

Is the service safe?

Our findings

At our previous inspection of this service in August 2017 we found the key area of 'Safe' to be Inadequate. We also identified breaches of Regulations 12 and 19. The breaches were in relation to people who did not receive consistently safe care and that the provider had failed to make sure that staff employed at the service were suitable and safe to undertake their roles. At this inspection we found that people were still not receiving safe care, and the service remained in breach of Regulation 12. However the provider had ensured that staff were now recruited well, and the service is no longer in breach of Regulation 19. We found the key area of 'safe' to remain Inadequate because sufficient improvements to ensure people's safety and well-being had not been made.

At our last two inspections we found that risks to people had been assessed by the provider. However, people's risks and changing needs were not monitored or updated in a way that kept people safe. At this inspection we found that this still had not improved. For example one person had a risk assessment in place that reflected the support they needed to keep them safe in the community. Staff told us about an incident where a person became very distressed while out, and we saw a comprehensive investigation that the manager had undertaken in relation to this incident. In that document the manager pointed out that because the risk assessments were not accessible to staff they were 'effectively useless.' They also said, "The current method of risk assessment is not fit for purpose. The assessments are non-specific … staff are not aware of the content of them…when the behaviour started the escort did not know what to do." The manager told us that the person was currently kept safe as they no longer accessed the community in the same way, however they had failed to update the risk assessment to ensure this person's ongoing safety.

During our previous inspection we identified that another person did not have a risk assessment in place to enable staff to support them with their on-going health concerns . Staff did not have the knowledge to consistently keep the person safe when they became ill. Staff we spoke with had some knowledge of the person's health support needs but this was not consistent and did not promote the person's safety. At this inspection we found that risks to the person from their health condition still had not been assessed or actions taken by the provider to keep them safe.

Therefore people remained at on going risk of receiving inappropriate or unsafe care. Staff did not have sufficient guidance or support to keep people safe and mitigate risk. The provider had failed to update care plans and risk assessments to provide adequate information to staff, despite previous inspection reports identifying these issues.

At our last inspection we found that medication was not administered safely. Since then the provider had introduced a new system of administering medication that was easier for staff. We found that staff had administered most medication more safely because of the new system. However, some people received their medicines in separate boxes that were not part of the new system of administering medication. We looked at the boxes and saw that not all of them had dates on when they had been opened. This is important to make sure they remain effective and don't go out of date. The provider also did not have a safe system in place to keep count of the numbers of tablets left in the boxes. Not having such a system means

that if there is a recording error, staff do not know if a tablet has been given to a person or not. This could put people at risk of not receiving their prescribed medicines.

We saw that people had new medicine cupboards in their bedrooms which were securely locked and the temperatures within them were clearly recorded. This meant that people's medicines were stored safely. We saw that there were now very few medication recording errors. However, where errors had occurred, they had not been addressed as part of the auditing of medication to ensure lessons were learnt For example some people did not receive their prescribed medication and this could have led to an increase in their anxiety. The medicine errors had gone unnoticed by the provider and actions to keep people safe had therefore not happened.

Some people needed medication on an 'as required' basis. Although guidelines for when to give these medicines had been written, they were stored away from the medicines and staff did not always know what these guidelines were, or where to locate them. We found that while these guidelines had been produced, they were not being used to ensure that people received their 'as required' medicines safely and as prescribed . For example it was not clear when people should receive medicines that helped them remain calm. Staff gave us inconsistent accounts as to when they would give the medicines which placed people at risk of unsafe medicine administration for as required medicines.

We discussed the use of 'homely medicines' with staff. These are over the counter medicines such as mild painkillers. One person had been using a homely medicine and this had not been checked with a healthcare professional to see if there were any potential side effects with the person's health or their other medicines. Staff told us that the person had experienced ill health because of this oversight. There was no process for auditing of any homely medicines that people were offered to ensure they were safe to administer.

We found that while there had been some improvements with how medicines had been administered since our last inspection, there were still areas of considerable concern which placed people at risk of harm.

People were not always protected from harm by the prevention and control of infection. Although, we saw that the home was generally clean, some areas of the home had broken, damaged and very well used furniture and fittings. For example in one bathroom the soap dish, waste bin and toilet brush were all broken and could harbour bacteria. Bedroom furniture was very well used and some chairs were ripped and torn. These items were hard to clean and keep free from bacteria. Only half the staff had undertaken Infection Control training, and the manager could not access the policy about Infection Control during our inspection of the service. Staff told us that they always had a supply of protective gloves and aprons to use when they supported people with personal care.

Staff told us that night staff were responsible for the overall cleanliness of the house and this was part of their duties. There were no audits undertaken to check if areas of the home had been cleaned to a suitable standard . The home did not have an Infection Control Lead, who is a member of staff who makes sure this area of work is kept up to date. We found that there was an 'ad hoc' approach to cleaning within the home and that Infection control practice and prevention within the home remained an area of concern.

We looked at how the provider learnt from mistakes and how they planned to improve their service as a result of that learning. We found that there were no systems or processes in place to do this. For example, at our previous two inspections we found that processes to reduce the likelihood of accidents and incidents happening again, were not in place. At this inspection we saw that the provider now used an accident book as a record of when accidents occurred. We noted however that this was used only as a list of accidents and that no analysis or learning had taken place as a result. For example one person had tripped over and this

had simply been recorded with no evidence of attempting to put any measures in place to reduce the likelihood of the person tripping again. This meant people were not protected from on going harm or a prevention of future incidents because of an inadequate oversight and response to incidents which had occurred.

The care and support people received was not safe and processes and checks were not in place to ensure safe care and treatment. This was a continued breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living at Ascot Villa, one person said, "It's safe and comfy here really." Relatives we spoke with had mixed opinions about how they felt their relatives were kept safe from harm. One relative said, "[My relative] is safe, they are never left alone." Another relative was not happy with how safe people were kept and described a recent incident where one person had not been supported in a way that kept them safe and well. Not everyone felt that Ascot Villa was a safe place to live.

The provider had a system in place to safeguard people from the risk of abuse and staff understood their responsibilities in relation to reporting safeguarding concerns. We saw that since our last inspection the provider had reported safeguarding concerns to the local authority appropriately. However, not all staff had received recent training in safeguarding and told us that it was booked to happen the day after our inspection. We found that while systems and processes to safeguard people were in place they were not always effective..

We saw that there were sufficient staff to support people in line with their care needs. During our inspection people were supported in a timely manner. All the relatives we spoke with told us that they had no concerns about the staffing levels within the home and we saw the rotas of the staff that showed the service made sure sufficient staff were available at all times.

At our last two inspections we found that the provider had not been recruiting staff safely. The recruitment processes were not robust and staff had been providing care and support to people when they may not have been suitable to undertake that role safely. At this inspection we found this had improved and that staff were now being recruited in a safe manner. We found that the breach of Regulation 19 had been met. We reviewed staff recruitment files and saw that the registered provider's recruitment process contained the relevant checks before staff worked with people. Staff told us that the provider had taken up references about them and they had been interviewed as part of the recruitment and selection process. The manager showed us the current DBS or police checks that they held for all of the staff who worked at Ascot Villa. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care.

Since our last inspection a new kitchen had been installed, and significant improvements made to the storage of food and the areas that it was prepared in. The service had recently been re rated by the Food Standards Agency and awarded the highest hygiene rating which meant that the service operated good food hygiene standards. Records showed that only half of the staff team had received food hygiene training, and further training was not planned. This meant that not all staff had the required knowledge to keep people safe from concerns around food hygiene.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection of this service on August 2017 we found the key area of 'Responsive' to require improvement. These concerns were identified as a breach of Regulation 9 whereby the provider had not done everything reasonably practicable to make sure people received care that was person centred and reflected their needs and preferences. At this inspection we found sufficient improvements had not been made and the service remained in breach of Regulation 9. We found the key area of 'responsive' to remain as Requires Improvement.

At our previous inspection we found that the service had not enabled people to be supported to communicate in a way that met their needs. At this inspection we found sufficient and timely improvements had not been made. No progress had been made since the last inspection in relation to obtaining, or starting the process to obtain, accessible aids for people to support their communication and enhance their well-being . For example, two people had limited verbal communication. Health professionals had advised the provider to use pictorial aids to support people and enhance their communication and engagement opportunities despite this being raised at our previous inspection, the provider had made no attempt to introduce these aids to assist people to communicate their needs and choices.

During the inspection staff told us that some people used Makaton (a form of sign language) but that staff had not had any training in this and did not know how to communicate with people who used it. This meant staff were not able to effectively engage with and support the communication of people who were able to use signs. Staff told us that one person had refused to wear their hearing aid for many months and while we noted they had seen their GP at that time, no further intervention had been taken by the service to enable the person to hear better and so improve their understanding and communication. We found that the service had not implemented the Accessible Information Standards which are a set of nationally recognised standards for meeting the communication needs relating to disability, impairment or sensory loss. The provider had not met the communication needs of people living at Ascot Villa and had made no attempts to maximise people's opportunity to engage, be involved and communicate their choices. This had a significant impact on people's well-being and quality of life.

Staff told us that they gave people choices and involved them in making decisions about their care and daily lives. During our inspection we saw that staff gave people choices on day to day matters, this included things like; where they wanted to be in the house, what food to eat and what activities to do. For example, people told us they had chosen the paint colour for their bedrooms. However, the provider did not have any system in place to involve people in making choices about their care where they were unable to communicate verbally. The lack of appropriate communication aids further negatively impacted this process. The provider did consult with people's relatives but this was inconsistent. We saw that one person, who was deemed not to have capacity to make decisions about their care, had signed their care records. Staff we spoke to about this thought it was appropriate that the person had done so, and that their signature represented the person's involvement and contribution . This was not appropriate as the person did not have the mental capacity to understand what they were signing. There was no other method in place to support people to contribute to their overall care plans, or plans for their future.

Since our last inspection a member of staff had been employed to focus on providing more meaningful activities for people. We found however that this had not had a positive impact for people. One relative told us, "I could not tell you of any activities in the home." One member of staff said, "There's not much development with activities, there's not much change really." Another member of staff told us that people were doing more but only more of the activities that they already did. A health care professional said, "[The home] just don't think beyond the shops and a walk around the block." We saw that some people's wishes and aspirations had been identified, but we noted that these had not been achieved in the majority of cases. For example one person had wanted to go swimming for many months and this had not been facilitated by the staff at the time of our inspection.

We saw that each person had records that told staff about their needs and preferences. The records varied in detail from person to person, and we found that not all staff knew everything they needed about all the people who lived at Ascot Villa. For example one person occasionally wanted a certain type of food, but this had not been offered to them so they could not choose it.

People were not actively encouraged to develop their independence. We found that where people did have some skills such as how to make a cup of tea, these skills were supported but not developed. The manager and staff said there was no programme or focus from the staff team to achieve aspects of independence that some people may be capable of. For example no one living at the home was supported to learn to cook simple meals, travel more independently, or develop new friendships or relationships. We found that the development of independent living skills had not been encouraged.

When we spoke with staff we noted that not all of them had experience or training around working with people with learning disabilities, and after the inspection the manager sent us information that showed that six of the 12 employed staff had no learning in relation to working with people with learning disabilities or autism. A health care professional told us that they kept advising staff about how to support people better, but the suggestions were not completed. For example they explained how they have suggested pictorial information for people. They said, "I've asked for that repeatedly, but it hasn't been done." Many staff did not have the skills and knowledge they needed to support people living at Ascot Villa appropriately and so care and support was not always provided in line with people's individual needs, preferences and choices.

The care and support people received was not person centred and did not reflected their needs and preferences. This was an on going breach of Regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged and helped to maintain contact with friends and family members, wherever possible. Relatives we spoke with said that they had regular contact with people in the home and were encouraged to visit and support people.

People told us they knew they could talk to the manager or staff if they had any concerns and during our inspection we saw that this happened. However it was not clear what actions were taken to respond to the issues that had been raised. For example not all concerns had been recorded and of those that had, actions to rectify the concerns had not happened consistently. When we visited the service at our last inspection, there was some information about the provider's complaints process on display in the main reception area but it was not in an accessible format for the people who lived at the home. This had not improved and no action had been taken by the provider to support people to have access to this information. We noted that the provider had a complaints procedure and the manager told us that one complaint had been received in the last 12 months. The records for this were not available for us to review at the inspections however.

Relatives we spoke with told us they did not have any complaints but if they did they would raise any concerns with the manager. Relatives said they felt that they would be listened to. Staff told us that complaints were now being dealt with well. One staff member said, "If there are any issues they are dealt with well and sorted."

Inadequate

Is the service well-led?

Our findings

At our previous inspection of this service we found the key area of 'Well Led' to be Inadequate. These concerns were identified as a breach of Regulation 17 and were in relation to an ineffective auditing and monitoring process to mitigate risks, improve quality or to adequately maintain contemporaneous and accurate records. At this inspection we found that sufficient and timely improvements had not been made and the service remains in breach of Regulation 17. We found that the service remained Inadequate in this key area.

There were systematic and widespread failings in the oversight and monitoring of the service which meant people did not always receive safe care which enhanced their well-being. Despite previous inspections identifying shortfalls to governance systems and the quality of care provided, we found that insufficient progress had been made to the auditing and governance systems of Ascot Villa. For example, the systems to oversee risk and safety remained ineffective because action had not been taken to address these issues. People's risks were still not recorded and updated as necessary which meant people were placed at risk of unsafe or inappropriate care Governance systems had not ensured care plans had been updated and therefore staff continued to be unaware of how to support all people safely. Although some staff training had improved since the last inspection, staff still did not have access to training and learning which would enable them to provide safe, effective care. For example, training around supporting people with learning disabilities or appropriate communication methods with people. Many of the people using the service required support with communication and the provider had not ensured staff had the skills required to communicate effectively with people which significantly impacted the quality of care people experienced.

The provider had completed an action plan in response to our previous inspection. However, the actions that had been detailed in the action plan had not been completed effectively , for example the introduction of an effective auditing process The oversight and monitoring of the service was ineffective and the providers systems had failed to ensure that previously breached regulations had been met.

The monitoring and oversight of the service remained ineffective and did not ensure the quality of service people received. The manager told us that a system of team leaders checking areas such as cleaning and health appointments for people was just about to start. However, on the day of our inspection one person was not taken to their hospital appointment. The impact of this oversight could have had serious consequences for the person in relation to their on-going health care. As the appointment needed to be rearranged, the person remained in pain and discomfort for longer than necessary as possible surgery had been delayed.

Oversight of incidents and accidents that had occurred was ineffective and did not ensure lessons were learnt and future risks mitigated against. The manager told us that there was no formal trends analysis of the incidents at the home. We were aware that each person's had daily notes made by staff but these were not reviewed by the provider to look for trends or themes We found that no actions had been taken since our last inspection to begin to monitor or audit key areas of the service as required. This meant that people were not consistently kept safe and that there was no overview of peoples changing needs and conditions

so that they could be supported appropriately.

Systems that had been introduced for monitoring risks were not reviewed. We saw a new process for checking the temperature of water had recently been introduced. However, this was ineffective because it was not being used and the water temperatures in the bathrooms were not being recorded and kept up to date. We looked at three bathrooms and in all of them we saw that the recording had stopped many weeks ago. In one bathroom staff had continued to use the temperature recording sheet to state that the bathroom had been cleaned. This error had not been recognised by staff or the provider as the monitoring had not been reviewed.

The provider did not understand the principles of good quality assurance and there had been very little improvement in this area since our last inspection or implementation of a robust improvement plan. The provider did not have a culture of learning from events or any tools to reflect on what had worked or not. There was no drive to make improvements or clear action plan to implement changes to the safety and quality of service. For example, health professionals continued to provide guidance and advice about how care could be enhanced or improved but the provider failed to implement any of these changes.

The assessment and monitoring of the service to mitigate risk and drive improvement was not effective. This was a continued breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we found that the new manager who had only been appointed very recently had a clear vision about how to improve the delivery of services to people who lived at Ascot Villa. One member of staff told us, "[The new manager] is really good, he knows his stuff and he puts things right." Another member of staff said, "It's getting better slowly, too slowly really." We found that while some areas of leadership had started to improve the positive impact for people had not yet been felt by them. For example, people were still not receiving care that was person centred or safe. Due to the very recent employment of the new manager staff were only just beginning to feel more supported and told us that there had been an increase in team meetings.

The provider had ensured that regulations relating to notifications had been met and the manager was returning notifications to us as required. The manager told us that the provider intended to support Ascot Villa to develop, and had made commitments to that end in the form of future investment in the building and its contents. Data was not managed robustly and during our inspection we found several examples of where information was misplaced or not available. For example a risk assessment and some PRN protocols could not be found for some hours. This meant that people were not supported in the correct way in a timely manner.

At the time of our inspection, surveys or other methods of collating opinions or views about the service provided had not been undertaken with people or their relatives. The manager advised that feedback was gained informally when relatives telephoned or visited, but there was no evidence that this had been used to improve the service to people This meant that opportunities had not been taken to gather feedback to improve the service for the people living at Ascot Villa.

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 The care and support people received was not person centred and did not reflected their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care and support people received was not safe and processes and checks were not in place to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The assessment and monitoring of the service to mitigate risk and drive improvement was not in place.