Hill Care 3 Limited

Pelton Grange Care Home

Inspection report

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Pelton
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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

This inspection took place on 24 May 2018 and was unannounced. Subsequent days of inspection took place on 29 and 30 May 2018 and were announced.

Pelton Grange 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. Pelton Grange provides personal care for up to 47 people. At the time of our inspection there were 35 people living at the home who received personal care, some of whom were living with a dementia.

A registered manager was not in place at the time of our inspection. 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. The previous manager had left the service six weeks earlier. The service was currently being managed by the deputy manager.

This is the first inspection of this service under the management of Hillcare 3 Limited. This service had been taken over by Hillcare 3 Limited since our last inspection in December 2015. Hillcare 3 Limited registered with the Care Quality Commission to manage this service in May 2017.

During this inspection we found breaches of Regulations12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because: pressure relieving mattresses were not set correctly; the administration of topical creams was not recorded accurately; people's medicine records lacking detailed guidance for staff relating to 'when required' medicines and transdermal patches; staff training and supervisions were not up to date; and the provider did not have effective quality assurance processes to monitor the quality and safety of the service.

We have made recommendations about recording decisions made in people's best interests and person-centred care planning.

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

People and relatives spoke positively about the service and said it was a safe place to live.

Staff knew how to respond to any allegations of abuse. Safeguarding referrals had been made to the local authority appropriately, in line with set protocols. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who used the service.

Accidents and incidents were recorded accurately and analysed regularly. Each person had an up to date

personal emergency evacuation plan should they need to be evacuated in the event of an emergency.

People had maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Fluid charts had not been completed accurately. People said the food was enjoyable.

People had access to important information about the service, including how to complain and how to access independent advice and assistance such as an advocate.

People and relatives we spoke with knew how to make a complaint. They told us they would speak to a member of staff or the manager if they had any issues.

Staff had a good understanding of people's care preferences but care records did not always contain up to date and relevant information about people's care needs.

People had access to a range of activities which they said they enjoyed.

People, relatives and staff told us the deputy manager (who was currently managing the service) was approachable.

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.

The guidance for staff on 'when required' medicines was not always clear. Record keeping in relation to topical medicines was not robust.

There was a persistent malodour on the first floor.

People told us they felt safe when receiving care and support.

Staff had completed safeguarding training and understood their responsibilities to report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training and supervisions were not up to date.

Decisions made in people's best interests were not always recorded accurately in line with the requirement of the Mental Capacity Act 2005.

People said they enjoyed the food.

People were supported to attend regular appointments with healthcare professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind and caring.

Staff were encouraging and respectful when supporting people.

Staff promoted independence without unnecessary risks to people's safety.

People had access to information about how to complain and how to access independent advice and assistance,

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always detailed and person-centred.

People were supported to participate in meaningful activities.

People and relatives knew how to make a complaint.

People's care plans contained their end of life preferences where appropriate.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A registered manager was not in post.

The provider's quality assurance system had not identified all of the concerns we found during this inspection.

People's feedback was sought and acted upon.

The home had good links with the community.

Pelton Grange 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 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 24, 29 and 30 May 2018. The first day of the inspection was unannounced which meant the provider did not know we would be visiting. The second and third days of inspection were announced so the provider knew we would be returning. The inspection was carried out by one adult social care inspector.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider 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.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team, and other professionals who worked with the service to gain their views of the care provided by Pelton Grange.

During the inspection we spent time with people living at the service. We spoke with 10 people and nine relatives. We also spoke with the manager, the provider's representative (the regional manager), two senior care assistants, four care assistants, the activities co-ordinator, the administrator, the maintenance person, two members of kitchen staff and two members of domestic staff. We spoke with an external health professional who was visiting the service during our visit.

We reviewed five people's care records and four staff recruitment files. We reviewed medicine administration records for 12 people as well as records relating to staff training, supervisions and the management of the service.

Due to the complex needs of some of the people living at the service we were not always able to gain their views about the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's care were not always identified and mitigated. We checked pressure relieving mattresses for four people. Out of the four we checked only one had been set correctly for the person's weight. There was no information about what setting mattresses should be at in people's care records which placed people at risk of pressure damage. This had not been identified by staff or management.

Staff we spoke with were unsure what settings pressure relieving mattresses should be set to for the individuals concerned and staff said they needed guidance on this. The deputy manager said, "The community nursing team routinely review pressure relieving equipment but staff need more guidance on this." The deputy manager took immediate action to rectify this during the inspection.

During our visit we were shown around the premises which included bathrooms and toilets. The flooring in one toilet on the first floor needed replacing as it was worn and could not be cleaned thoroughly. We noted there was a persistent malodour on the first floor as a result of this and the carpets in some bedrooms. Despite regular cleaning of these areas the malodour persisted which indicated some of the flooring needed replacing. When we spoke with the deputy manager they said a refurbishment plan was in place and the flooring in this toilet and in bedrooms was due to be replaced shortly. We noted damage to the plaster above a bedroom door which needed to be repaired. The deputy manager told us this was also on the refurbishment plan to be addressed shortly. They said, "The provider is quite happy spending money on the building."

Medicines were not always managed effectively and safely. Topical medicine application records (TMARs) and body maps to highlight where staff should apply prescribed creams and ointments were in place, but three records we viewed relating to topical medicines were incomplete. Staff told us where people's creams needed to be applied and how often, but incomplete records meant we could not be sure prescribed creams had been administered in the right way or at the right frequency, in line with the instructions on people's prescriptions.

Records and guidance relating to one person's transdermal patch were incomplete. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine into the bloodstream. The patch being used should not be left on the skin for more than 12 hours but there was no guidance on this for staff to refer to. This meant we could not be sure this person's transdermal patch was being administered safely and in line with the instructions on their prescription. When we spoke with the deputy manager about this they said they would deal with this immediately.

Some people's medicine records lacked detailed guidance for staff relating to 'when required' medicines. Some people were prescribed pain relief such as paracetamol to be taken 'when required' or medicine to treat extreme anxiety, but there was not always detailed guidance in place to assist staff in their decision making about when it could and should be used. Staff described when they would administer 'when required' medicines but there was not always clear guidance for them to refer to. This meant people could be at risk of not receiving medicines when they needed them, particularly those who could not always

communicate their needs.

Three people did not have photographs on their medicine records. This increased the risk of mistaken identity when staff administered medicines. As the service was currently using agency staff this risk was particularly relevant.

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

Medicines that are liable to misuse, called controlled drugs were recorded and stored appropriately. Records relating to controlled drugs had been completed correctly. The temperature of treatment rooms and the clinical fridges were checked daily and were within recommended limits for safe storage. Staff who administered people's medicines had received training and been assessed to check they were competent to carry out this role.

People we spoke with said they felt safe living at Pelton Grange. One person told us, "I feel safe here as I get looked after properly." Another person said, "I feel very safe and secure as I'm treated very well."

Safeguarding referrals had been made and investigated appropriately. A log of all concerns was kept up to date and staff had access to relevant procedures and guidance. Staff understood their safeguarding responsibilities and told us they would have no hesitation in reporting any concerns about the safety or care of people who lived there. Staff said they felt confident the deputy manager would deal with safeguarding concerns appropriately.

Recruitment and selection procedures were effective. Relevant security and identification checks were carried out before new staff were employed to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and reduces the risk of unsuitable people working with children and vulnerable adults.

People and relatives said there were enough staff on duty. We spent time observing staff responses throughout the inspection. We did not witness call bells ringing for long periods and noted that when people called for assistance this was given within a reasonable response time. This meant there were enough staff to meet people's needs promptly.

We noted that on one of the days we visited two members of agency staff were being used to cover shortfalls. One relative commented about this, "I'm happy with the care here but I would prefer more consistent staff." The deputy manager told us agency staff were occasionally used to cover staff sickness and holidays.

Risks to people's health and safety were recorded in people's care files. These included risk assessments about falls, pressure damage and nutrition. Regular planned and preventative maintenance checks and repairs were carried out by a maintenance person employed by the service. These included regular checks of the premises and equipment such as fire extinguishers, water temperatures, emergency lights, falls sensors and call bells. Other maintenance checks such as electrical and gas safety checks were carried out by external contractors. The records of these checks were up to date.

Each person had a personal emergency evacuation plan (PEEP) which contained details about their

individual needs, should they need to be evacuated from the building in an emergency. They contained clear step by step guidance for staff about how to communicate and support people in the event of an emergency evacuation.

Accidents and incidents were recorded accurately and analysed regularly in relation to date, time and location to look for trends. Recent analysis showed falls happened mainly between 1700 and 2000 hrs in people's bedrooms or in the lounges and staff were reminded to be vigilant. Records showed appropriate action had been taken by staff, such as referring a person to the falls team or obtaining assistive technology to prevent recurrence.

There were mostly effective systems in place to reduce the risk and spread of infection. Records showed all areas of the service were cleaned regularly. We saw that personal protective equipment such as gloves and aprons were readily available and liquid soap and hand gels were provided. As previously stated earlier in this section, some flooring was worn which could not be cleaned thoroughly so needed to be replaced.

Requires Improvement

Is the service effective?

Our findings

The provider used an electronic matrix to monitor and record staff training. We reviewed the training matrix and found training in key areas was not up to date. For example, 18 out of 38 staff had not completed up to date fire safety training, 14 staff had not completed any health and safety training and 20 out of 38 staff had not completed up to date safeguarding training. Pelton Grange provides care for people who are living with dementia, however only 20 out of 38 staff had completed dementia training.

Staff did not receive regular supervision and an annual appraisal. One staff member had received three supervisions in the last 12 months, but the provider's policy stated they should have received six. Supervision records for three staff members revealed they had not had any supervision in the last 12 months. Supervisions are regular meetings between a staff member and their supervisor to discuss how their work is progressing and where both parties can raise any issues to do with their role or about the people they provide care for. This meant staff had not been given formal opportunities to discuss their performance and training needs with their manager.

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

When we spoke to the deputy manager and provider about staff training they said the training matrix was up to date and they were aware staff training was an issue. The deputy manager told us, and records confirmed, some training had already been arranged to address this. Audits revealed the provider was already aware supervisions and appraisals had not been happening regularly and were taking action to address this.

A staff member said, "We've had enough training. We've had more since this provider took over. We get supervisions quite often and I feel supported." Most staff said they felt supported although one staff member said, "There have been a lot of changes and I don't feel that well supported, but I hope things will improve and that things will settle down a bit."

There was a lack of visual or tactile items to engage people living with dementia; such items can help engage people living with dementia and help reduce their anxiety. There was a lack of pictorial signage to support people with communication needs. Written menus were in place in the dining rooms but some people who used the service would not have been able to understand these and could benefit from menus in picture format. This meant information was not always provided in a format appropriate to people's needs.

When we spoke with the deputy manager and provider about this they said they were looking at ways to improve this as part of the refurbishment plan.

We reviewed people's records relating to nutrition. People were weighed when necessary and their BMI (body mass index) calculated. Food and fluid charts were in place where appropriate. Fluid charts were not always completed fully as a person's target daily intake range was not always specified, people's daily intake

was not totalled at the end of each 24 hour period and charts were not always checked for completeness. Staff knew which people needed prompting to eat or drink but this wasn't always captured in people's care records. Staff we spoke with had a good understanding of people's dietary needs and what to do if they were concerned but this was not documented. When we mentioned this to the deputy manager they said they would rectify this immediately.

We observed lunch time during our inspection. There were enough staff to support people to eat. Tables were nicely set with tablecloths, cutlery, serviettes and condiments. On the first day of inspection lunch was a choice of sausages and mash or chicken casserole followed by a hot pudding and custard. Other options such as salad or sandwiches were also available, although we noted that staff did not always readily offer these when people were asked what they would like to eat a few hours before the meal was served.

Meals were hot, cooked with fresh ingredients and looked appetising. Hot and cold drinks were readily available depending on people's preferences. Staff asked people if they would like an apron to protect their clothes and discreetly supported people to clean their face and hands after they had eaten. The dining experience was pleasant and relaxed, although we noted there were some periods when people were left unsupervised for short periods of time. We told the deputy manager and provider about this.

People said they enjoyed their lunch. One person said, "It was lovely, I really enjoyed it." Another person said, "The food is excellent here. We get plenty of it and are always asked if we want extra. You can always have something else too."

People were supported to access appointments with healthcare professionals such as the GP, occupational therapist and community nurse. Referrals to the falls team, dietician and other health care professionals were made appropriately and care plans reflected the advice and guidance provided by healthcare professionals. This demonstrated that staff worked with various healthcare agencies and sought professional advice, to ensure that the individual needs of people were being met, to maintain their health and wellbeing.

An external health professional who was visiting the service during our visit said, "I'm in the home every day and I've never had any concerns. The staff are great, always friendly and willing to help. I do a ward round to check dressings etc and the staff always follow my instructions. [Deputy manager] runs the home ship shape."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that DoLS applications had been made and authorised for four people by the relevant local authorities. Records showed decisions had not been made in two people's best interests in conjunction with their family members, staff members and professionals, regarding the use of bed rails. Family members told

us they had been involved in such decisions but records didn't reflect this. When we mentioned this to the deputy manager they said they would deal with this.

We recommend the provider reviews its best interest process in line with current guidance.

Staff told us how they involved people to make their own decisions where possible, for example when choosing how to spend their time or what to wear. During our inspection, we observed that staff sought people's consent before carrying out care tasks or involving them in activities. This meant the service was mostly meeting the requirements of the MCA.

Good

Is the service caring?

Our findings

All of the people we spoke with told us staff were kind and caring, and they were happy with the care they received at Pelton Grange. Their comments included, "The staff are good, honestly can't fault them," "I'm well looked after here and the staff are lovely," "The staff are lovely here, really nice. They make sure I'm well cared for" and "The staff treat me very well."

Relatives spoke positively about the care provided. One relative said, "The staff are lovely and kind. I know [family member] is well looked after. We're both really happy with the care here." Another relative told us, "I come in everyday and I'm happy with the care. When I first came to view the home I just called in without making an appointment and I liked what I saw. My [family member] has a nice room and has settled in well. I know if I want anything at all I only have to ask the staff."

Relatives and friends were welcomed into the service and people were encouraged to maintain links with their family and friends. One relative told us, "I'm always made to feel welcome. I know all the staff now."

All of the people we spoke with felt staff demonstrated respect and acknowledged their privacy. For example, people told us how staff ensured curtains were pulled across and doors closed to ensure privacy was maintained when people were supported with personal care.

Some people were unable to fully communicate their opinions about the care they received, but we observed positive relationships between staff and people living at the service. People's facial expressions and body language showed they were comfortable in the presence of staff and enjoyed a laugh and a joke with them. Throughout our visit staff spoke with people in a kind and considerate manner. Staff knew people's needs and preferences well. For example, staff offered one person a glass of milk as they knew this person didn't like hot drinks.

Staff were encouraging and respectful when supporting people. For example, when supporting people to move from the dining room to the lounge staff interacted with the person and explained what they were doing, which put the person at ease. We saw staff reassured people when they were anxious or upset in a kind and gentle way.

Staff promoted independence but were quick to offer support when needed. For example, we heard one staff member ask, "Would you like me to walk with you to the dining room?" to which the person replied, "Oh yes please."

Staff spoke about the people they supported with affection and respect. A staff member told us, "I love my job. The residents are great and I love the banter with them."

People had access to information about how to complain and how to access independent advice and assistance, such as an advocate if they needed it. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions. The deputy manager told us no one who used the service

had an advocate as people all had family members to advocate for them.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always detailed, personalised and up to date. For example, some care plans did not contain a photograph of the person or any information about a person's likes and dislikes and how they wished to be supported as an individual. Some care plans did not contain information about people's social history and family background, although some staff we spoke with could tell us about this. Staff need this information so they can get to know people as individuals.

Some care plans we viewed did not record how a person or their representative had been involved in the care planning process. This meant we could not be sure whether people and their representatives had been involved.

When we spoke with the deputy manager and provider about this they acknowledged care plans needed improving and work was already underway to address this.

We recommend the provider seeks advice from a reputable source on person-centred care planning and how people and their representatives can be involved in the care planning process.

People were supported to take part in meaningful activities and access the local community. The provider employed an activities co-ordinator who spoke enthusiastically about their role and their plans to further develop the activities programme, with input from people who used the service. A variety of activities were available which included pamper sessions, knit and natter, cards, dominoes, karaoke, reminiscence sessions, chair exercises, make your own pizzas, Macmillan coffee mornings, trips out, events for Sports Relief, puppet shows and pie and pea suppers.

There were raised beds in the garden which were accessible for people with mobility issues. Children from the local school visited the service every few weeks to spend time gardening with people. People told us they enjoyed this.

During our visit some people enjoyed a game of bingo. One person who won a game of bingo said, "I really enjoyed that. I've never been so lucky in my life." Staff supported this person to pick a prize from a 'goodies trolley' which contained sweets, chocolates and toiletries.

People told us how much they enjoyed it when outside entertainers visited the home. During our visit a magician came to entertain people in communal areas and on an individual basis in their rooms, which meant everybody was included. People told us how much they had enjoyed the magician who had a good rapport with people. We heard people and staff making plans for the summer fair. One person said they would like to help with the tombola and selling raffle tickets.

People and relatives knew how to make a complaint. People and relatives told us they would speak to staff if they had concerns about anything, however small. A relative told us, "I've only had to complain once which was recently. It was upsetting at the time but I'm happy with the way it was dealt with." A person said,

"I've got no complaints at all."

The deputy manager and provider told us how they had recently audited complaints and felt some had not been responded to appropriately so they were re-opened. Records of complaints, including those re-opened, showed that complaints were now responded to appropriately and in line with the provider's policy.

We saw that where possible, people remained at the service at the end of their lives, as long as they did not require specialist care that could only be provided at a hospital. People's care plans reflected their preferences, where people felt able to discuss this sensitive area. This meant staff had information to refer to about the person's wishes should the person not be able to make their wishes known. For example, one person's care records stated what music they wanted to listen to when they approached the end of their life and what funeral director they wanted to be used.

Requires Improvement

Is the service well-led?

Our findings

The provider had a quality monitoring or audit system in place to review areas such as safeguarding, complaints, medicines and care plans. Recent audits identified a number of areas for improvement such as care plans, staff training and supervisions and issues relating to the environment. However, improvements had not been made in a timely way and the provider had not identified other areas for improvement that we found during this inspection such as: pressure relieving mattresses not being set correctly; the administration of topical creams not being recorded accurately; and people's medicine records lacking detailed guidance for staff relating to 'when required' medicines and transdermal patches.

Whilst people had not suffered any pressure damage as a result of pressure relieving mattresses not being set correctly for their individual weights, their risk of pressure damage was increased. Over inflation and under inflation of pressure relieving mattresses can cause skin damage due to the mattress being too hard or too soft, and can be uncomfortable for a person to use. This meant the provider's quality monitoring system was not always effective in identifying and generating improvements within the service.

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

A registered manager was not in place at the time of our inspection so the rating for this section is limited to requires improvement. The previous registered manager had left the service six weeks before out visit. The deputy manager was currently managing the service and a permanent manager was being recruited. The deputy manager had worked in the care sector for several years and worked at the service since 2016. After our visit we were told that the deputy manager had been successful in obtaining the permanent manager's post and had already begun the process of applying to the Care Quality Commission to become the registered manager.

The deputy manager and provider acknowledged that staff had been unsettled when the previous registered manager left and things had been difficult. The deputy manager said, "Things have been unsettled since the previous manager left but [regional manager] is here several times a week to provide support and they're very hands on. I like working for this provider as it's a smaller organisation and they went to provide good quality care."

People, relatives and staff spoke positively about the deputy manager. One person said, "[Deputy manager] is nice. Always on hand to speak to." A relative told us, "Everyone knows [deputy manager]. I'm sure they'll do a good job as they deal with things straight away." A staff member told us, "[Deputy manager] is supportive and there when needed." Another staff member said, "[Deputy manager] is supportive. We always bounce ideas off each other."

We were assisted throughout the inspection by the deputy manager and the provider's regional manager. All records we requested to view were produced promptly.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'. The provider had made timely notifications to the CQC when required in relation to significant events that had occurred in the home.

The home had good links with the local school, church, football club and a local artist whose work was on display at the home.

People's feedback was sought regularly and acted upon. For example, people had been consulted on the choice of wallpaper when one of the lounges was re-decorated. People's written comments included, 'It's lovely' and 'You've done a really good job.' Some people said the food was sometimes cold so the provider had bought hot trollies to serve the meals from. People said this was much better.

Feedback from people, relatives and professionals was sought regularly via an annual survey. Six relatives, one resident and one professional had responded to the most recent survey in November 2017. All respondents said they would recommend Pelton Grange to others.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care were not always identified and mitigated. Medicines were not always managed safely and effectively. Regulation 12 (a) (b) (d) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance system had not identified all of the concerns we found during this inspection. Regulation 17 (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff training in key areas and supervisions and appraisals were not up to date. Regulation 18 (2) (a)