Hilbre Care Limited

Hilbre Manor EMI Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on the 29 September and 1 October 2015 and was unannounced. The inspection was the first since the service had been registered in July 2015.

Hilbre Manor EMI Residential Home was a large, Victorian building which had recently been refurbished.

The home was registered to provide care and accommodation for up to 12 people. At the time of our inspection, there were eight people living in the home. One person was currently being supported by District Nurses as the home did not provide nursing care. Most people at the home had some confusion or dementia type conditions.

The home required a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

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.

There had been two registered managers and both had resigned and left their post, the previous week. Management of the home was being done by the provider, who had recently appointed another manager. This person was present in the home during our inspection, having had all the required checks, although they had yet to formally take up the post. However, they too left the service shortly after our inspection, we were later told.

Medication administration was poor. The refurbishment in some areas of the home was incomplete. Subsequently, there were concerns over medicines and food storage, infection control and fire safety. Care records had been completed erratically, the appropriate assessments for capacity and best interests had not been done or the appropriate applications for Deprivation of Liberty, made to the local authority. Safeguarding concerns had not been forwarded to the local authority in a timely manner, nor statutory notifications made to CQC. The management of the home was chaotic.

We made a recommendation about appropriate physical environments for people living with dementia.

We identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 and the Care Quality Commission (Registration) Regulations 2009. These were in relation to medicines management, care records, safeguarding, the need for consent, for failure to notify CQC of certain events and the governance and management of the service.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

We found errors with the medication administration and the storage of medicines was poor. Some recruitment and employment processes were not completed.

There were fire safety issues as doors were propped open without the appropriate automatic closures. The home was still in need of works in order for it to be a safe place to live in.

Safeguarding concerns had not been addressed or reported appropriately

Requires improvement

Is the service effective?
The service was not always effective.

Staff from the providers' other homes were deployed because the home did not have its own dedicated staff team.

The appropriate capacity assessments had not been made or procedures followed. Consent therefore had not been legally obtained.

Requires improvement

Is the service caring?
The service was not always caring.

People told us they felt happy in the home and one relative told us they were happy with the care.

People were not treated with dignity or respect as there were no locks on communal toilets and bathrooms and staff talked about them, in front of them.

Requires improvement

Is the service responsive?
The service was not always responsive.

Care plans were not person centred and appropriate assessments had not been completed. Where there had been incidents, there were no corresponding reviews or action plans to address these areas of concern

Requires improvement

Is the service well-led?
The service was not always well led.

There was no registered manager in place.

The service was not able to demonstrate that there were appropriate checks, systems and policies in place in order to deliver high quality care.

Requires improvement

Hilbre Manor EMI Residential 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.

We inspected this service on 29 September and 1 October 2015 and the inspection was unannounced.

This inspection was conducted by one adult social care inspector. We had received information of concern and had discussed the service with the local authority quality assurance team.

During the inspection, we talked with five people who used the service, with four staff and we looked at records related to running the service, including eight care files and staff records. Much of the recording for this home was kept electronically. We also toured the building and talked with, and observed, the people who lived there. We observed the interactions of staff with these people and talked with a relative.

During and after the inspection, we were in close contact with the local authority.

Requires improvement

Is the service safe?

Our findings

One person told us, "I actually feel safe here".

Another told us, "They [staff] don't explain what my meds are. They just pop it into my hand".

A member of staff told us, "I know the staff have been told not to wedge the doors open. I know the provider has told them. I don't know where the rubber door wedges came from".

We were told that the house had previously been a nursing home which had closed. The building had been brought by the current owner some time ago and had recently been refurbished and re-opened as a residential care home. This had been done to a high standard in most areas, but some areas needed completion.

We saw that fire doors were propped or wedged open. These doors did not have self- closing devices linked to the fire alarm system. This meant that in the event of a fire and the ensuing emergency evacuation, they would not protect the rooms or areas that they were meant to. We discussed this with the provider during the inspection and consulted the fire protection officer for the area. We were reassured by the provider that closure fitments would be installed immediately and we saw that the maintenance person ordered them during the inspection process. The fire safety officer confirmed to us later that these had been fitted when they visited the home on 2 October 2015, the day after our inspection.

We saw a record that one person who lived in the home had let themselves out through the emergency fire door which was not alarmed appropriately to alert staff that this had happened. We also saw one emergency exit blocked by a commode being placed in front of it. We saw the fire safety logbook but there were no entries to show that systems have been tested or that fire training and drills had taken place.

There were folders in the office relating to personal evacuation plans and fire risk assessments, but these were empty. We were told that these plans and assessments should have been done by the previous managers. The fire safety officer later told us that they too had advised that these plans and risk assessments should be completed. In addition the fire safety officer had recommended that staff training was needed in respect of fire safety and that fire safety checks be recorded in the fire safety log book. The officer told the home that they needed to complete a fire safety audit in the near future.

In the care records we saw that some risk assessments had been completed for some of the people living in the home; an example was that some people had their hydration and nutrition risk assessments done. However we saw that some care records had no risk assessments of any sort. The new manager, who had yet to formally take up the post, told us that they would address this as a matter of urgency. Following our inspection, we received information from the local authority that these concerns had been addressed.

We saw that a boundary wall in the garden had partially fallen down. This allowed access to the property next door which in turn had access available to the road. There was also a large pond in the garden, adjacent to the house, which was uncovered and unfenced. We were told that access to the garden would be restricted until the wall had been repaired and that the pond would be protected. The local authority subsequently has told us that restriction had been put in place and the pond had been covered.

When we visited the kitchen which was situated in the basement of the building, we noticed that there was very little storage for vegetables, dry or tinned food products. Boxes of these were placed on the floor. This meant that food was not hygienically stored. We were told by the provider and staff, that work was still to be done and as an example, were shown a large cupboard which had no shelving. We were informed that this was due to be shelved and then would be able to store a lot of the food. This was part of the planned work which we the provider said should commence the following Monday when the builders should be back working. In addition we were told that other improvements to the kitchen area would be made, including more work surfaces and storage and the completion of some tiling works. The kitchen appeared clean, had a large range cooker, some kitchen work units and surfaces and fridge and freezer units. The cook, who had recently been employed, showed us records which noted that temperatures of the fridge and freezer had been taken twice daily and had been well within the required range. There were also records to show the temperatures of cooked food had been taken and that they had been within the appropriate temperature recommendations.

Requires improvement

Is the service safe?

The laundry room was not equipped with a sluice sink or hand washing sink. This meant that effective cleansing and infection control was difficult to achieve. The room itself was untidy and in need of decoration and tiling. There were several other areas in the basement which also needed to be tiled and otherwise completed, such as the floor.

There were either un- lockable window restrictors or none at all throughout the home. This meant that people were at risk of falling from windows. The provider told us that this would be rectified by the builders urgently. In the communal showers and bathrooms there were no soap dispensers, paper towels or hand washing signs and most did not have bins.

We were told by the provider that the builders had been sent away on the Monday prior to our inspection because the local authority team were present and were investigating some of the allegations made by a previous staff member. The provider told us that they would make sure that the builders recommenced their work the following week. The builders, we were told, would be completing the kitchen, laundry room, tiling and other works in house.

We looked at the medication records, the medication trolley and the medication room. The medication room was unfitted and only contained the medication trolley and a lockable fridge, with some boxes of diabetic equipment on the floor. The fridge was directly in front of an un-shaded window and at the time of our inspection, was in full sun. The temperature of the fridge had been recorded daily but were seen to be in excess of the recommended 5°C on several days. We noted that some temperatures had reached 7°C on these days. This meant that medication was not being stored at a safe temperature. We discussed this with staff who told us that they would move the fridge to a more suitable place in the room and shade the window. The provider also told us that plans were in hand to fit the medication room with a suitable lockable cabinet for any controlled drugs and also fit other suitable storage for equipment.

We had been alerted by a former staff member that there had been many medication errors. We checked the accidents and incidents records for medication errors which had been recorded. We found that there had been many errors, mainly to do with drugs counts or lack of signatures. There were some notes that people had been given the incorrect amount of PRN drugs (as required), usually paracetamol or aspirin. It was noted in these records that medical advice had been sought and no harm had been done.

On the first day of the inspection we checked the medication administration records (MAR) against the stocks of prescribed medication held in the trolley. We saw that there were many missing entries on the MAR sheets. However, the amounts of medication in the trolley indicated that there had been no omissions of administration, apart from one drug, lorazepan. This indicated that the MAR sheets had not been appropriately completed.

There were no controlled drugs stored apart from the lorazepam. We found that the MAR sheet which related to the lorazepam did not tally with the amount of lorazepam in stock. This was rechecked with the provider present, who could not provide a reason for this discrepancy. On the second day of the inspection we were told and shown that the lorazepam had been found in a filing cabinet. This is meant that although the correct amount of lorazepam was accounted for, it was not stored safely or in the correct place.

A member of staff had been charged with bringing the MAR sheets up-to-date and with reorganising the medicine trolley and on the second day of our inspection we saw that this was in progress. They told us, “Things have to be organised, we need a controlled drugs cabinet and book".

We discussed with the provider the inadequacy of their current medication systems and arrangements. They immediately made arrangements with their preferred pharmacy to come in to the home on Friday 2 October 2015. This was to enable the pharmacy to audit the medication and MAR sheets and suggest improvements to the way the home managed people's medication.

These examples are breaches of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not providing safe care and treatment for people living in the home.

The emergency call bell system only sounded in the office on the first floor, which was often locked. This meant that unless staff were in the office they would not hear if people

Requires improvement

Is the service safe?

used their bells to call for assistance. We have, since the inspection, received confirmation that the system will be upgraded to enable staff to hear the bells wherever they are in the home.

We saw that staff recruitment had generally followed safe procedures. Staff were eligible to work in the UK, had had the correct criminal records checks completed, had had at least two references and had completed an application form and had an interview. Many of the staff were employed by the provider and rotated through their other homes, others were agency workers. Most of the staff had been working at Hilbre Manor for some time and people told us that, "Most of girls are lovely; I feel safe here".

However we saw that one person had been employed before the criminal record check had been returned. We were told that they had worked under supervision until the check had been returned. This is not best practice. We also found that another staff member had been employed on the basis of only one reference where two should have been obtained.

A self-employed staff member told us that they hadn't completed a criminal records check prior to working with vulnerable people. They told us that they didn't think they had to because they weren't technically a member of staff of the home. This is not the case. This person's skills were used more or less full-time by the provider in all their homes and they worked with vulnerable people. On the first day of our inspection we had also seen this person and another member of staff help a person who had tripped at the entrance to the home, but they had both used a method of support which is high risk to the person and has now been discredited. This meant that vulnerable people were not protected properly by people who were looking after them.

We did not see any notices of how to report abuse or contact numbers in their home and we did not see any policies relating to safeguarding adults. We did see in the records that staff had been trained in safeguarding and that this had been refreshed regularly. One member of staff was able to tell us what safeguarding was, how to prevent abuse and how to report it if it did occur. The staff member also told us that the policies were held in another of the providers' homes and they had not yet been provided for this home. However another staff member did not know what to do about abuse or who to report it to.

The concerns which we were informed about, which related to safeguarding issues, should have also notified as soon as they occurred, to the local authority, as required by the safeguarding protocols which the provider had signed up to. This meant that the provider's own safeguarding policy and the local authority safeguarding adults policy, procedure and guidance, had not been followed.

These examples are breaches of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, service users are not appropriately protected from potential abuse and improper treatment.

We looked at the staff rotas for the current week and for the four weeks prior to our inspection and looked at the proposed staff rota for the following week. We had been told that one person who lived in the home, required two hourly turning throughout the day and night. Prior to the week of the inspection, there was only one sleeping member of staff on duty during the night hours. This was reflected in the rotas. This meant that the person requiring turning was not turned safely by two staff members and may have not been turned at the required intervals, due to the staff member being asleep. The local authority had been concerned about this and discussed this with the provider. Since then, from the Friday before our inspection, there had been two waking staff on duty throughout the night.

The current rota showed that there were three staff on duty until two o'clock in the afternoon and then there were two staff on duty for the remainder of the time including the night shifts. The staff had been drafted in from the provider's other homes and were working additional hours. The home had a cleaner and shared a maintenance person with the provider's other homes.

A cook had recently been appointed and had started work the week before our inspection. When the cook was not working we were told that staff cooked and prepared meals. We were told that active recruitment was taking place to staff the home and that if the numbers of people living there increased, staff numbers would increase accordingly. At the time of the inspection a new manager was currently at the home with a view to taking a permanent post and seeking registration. We have subsequently been advised that this person has now resigned.

Requires improvement

Is the service effective?

Our findings

One person told us, “I don't think they are trained".

Another person said, “We are not allowed out on our own; there is a restriction".

The home had a locked front door but people told us that they were not allowed to go out on their own; one person told us that it was, “The rules”. A relative, when we them asked about their view about the locked front door, said, ”I did wonder about whether it should be locked or not”.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the provider.

When we looked at the care records we saw that six people had notes in their files which indicated that they lacked capacity in some aspects of their lives. These people had been identified as needing a capacity assessment and /or a DoLS application but we did not see that anything had happened relating to these nor did we see that any best interest meetings had taken place. Examples of these are that one care record contained an entry which said that the person was, 'Deemed to lack capacity and wants to leave the building on his own'. Another record told us, ‘Cannot understand, retain or make decisions’. A third record told of an event where another person tried to smash the front door with a fire extinguisher in order to try and leave the building.

Three people had been transferred from the provider’s other homes and these people, at the time of our inspection, were being assessed for their capacity to make this decision to move. This is because the local authority had identified that this had not been done at the time of their move as it should have.

We saw that staff had training in MCA and DoLS and one staff member told us, “It’s a complicated subject". This person was not able to tell us about the principles of MCA.

These examples are breaches of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent.

The carpeting and soft furnishings of the home were of good standard, but the home was not finished or decorated in a way that was conducive for people with dementia to live in. Best practice suggests that minimal patterning and the appropriate use of colour and contrast offers an appropriate environment for people with dementia. All the doors and walls throughout the home were in a neutral colour and doors did not have any identification apart from a number, to indicate whose room it was or whether it was a toilet or a cupboard. The carpet throughout the home was spotted and curtains were also heavily patterned. Signage generally throughout the home was minimal and not pictorial, as best practice recommends.

Records showed us that staff had received an induction to the role and had been subsequently trained in areas such as medication administration, moving and handling, infection control and safeguarding. Staff told us that a lot of their training was done through e-learning and that they did not like this. Staff received regular supervision and appraisal and told us that they felt well supported. Some staff had been with the provider for many years.

The maintenance contractor told us that they had received training in fire safety procedures and the lifting course but that they "Knew I had lifted badly the other day. I just wanted to get her off the floor when she told me she was okay”. This meant that this staff member had not put into practice the training that they had received.

We joined the people lived at home for lunch on the first day of our inspection. The dining room contained tables, each for four people and were grouped informally. The table decorations and the cutlery and crockery were attractive. It was clear from the chatter and laughter at lunch time that mealtimes were relaxed and informal. People told us, and we could see for ourselves, that they could choose what to eat from a choice of freshly prepared food. We sampled the food and found it to be hot and tasty. People told us, “The food was okay", "It was lovely" and "It was delicious". We saw that there was a choice of pudding but that there was no choice about whether the rice pudding was served with or without jam. One person told us that the rice pudding was, "Definitely one of the nicest things we have had", but another person did not want what

Requires improvement

Is the service effective?

was available and the cook provided them with fruit and cream. We had seen in the kitchen that there was a chart showing who was diabetic and who needed fortified foods or gluten-free diets. The cook told us that they could accommodate any dietary needs or preferences and that there was always an alternative choice. They told us that they had just bought a book so that they could prepare and cook gluten-free recipes.

The cook told us that they had plans to pre-prepare some meals for days when they were not on duty so that staff would be able to reheat things appropriately. The cook also told us and showed us that they had designed charts to show that temperatures of food were recorded by everybody who used the kitchen to prepare food and had also devised a cleaning routine chart.

We recommend that the provider seeks appropriate guidance relating to dementia friendly physical environments.

Requires improvement

Is the service caring?

Our findings

One person told us, “It’s a lovely house and home”, but another told us that they had, “Experienced some pretty awful homes, it's hard to say about this one until it settles down".

Another person told us, “This is very good, this home. I can't fault it".

A relative we spoke with told us, “The care has been absolutely fantastic they were lovely with my dad and mum. Mum has perked up since she came here; her end of life care is very good".

This relative told us that the provider had been very accommodating to her parents needs and had arranged for one of them to be moved to this home in order to facilitate more frequent visits.

Staff we talked with were very concerned that people were cared for properly whilst recruitment was taking place. One staff member told us, “I’m going to work here until people are hired”.

We saw that generally, staff interacted very well with the people living in the home. The people seemed very at ease with the staff and we witnessed lots of good-natured banter and other exchanges.

Staff were very courteous with the people, who responded well. Whilst we saw that people were treated on the whole, with care, dignity and respect we, were told by a member of staff, "They are all quite sensible, no capacity issues". This was said in full hearing of the people who were in the lounge which did not demonstrate respect for the dignity of the people in the lounge.

There were no locks on the communal toilets or on people's bedroom doors. This, coupled with the lack of identification on the doors could easily lead to a lack of dignity and privacy for people using the toilet facilities or for people wanting privacy in their own rooms.

We heard that people were given explanations and information about what was happening to them and things relating to the home. One person told us, “They do everything they can to let you know”. However, there was no information available in communal areas about any events that might be happening or any other information that was meant for people who lived in the home.

Records were kept confidentially, with passwords required for the IT system and others were kept locked in the office.

Requires improvement

Is the service responsive?

Our findings

One person told us, “We don't do any activities; not been open long enough to get organised". They went on to say, "We just sit and watch TV and talk to each other. Some people have that angry hat on".

Another person told us, "We went out yesterday to the museum".

One staff member told us that they had been trained to work holistically with people and to consider all their needs in a rounded way.

Staff told us that they often did not look at the care files but relied on the handover between shifts and their own intuition, in order to care for people who lived in the home.

We saw that people's records were mostly kept online which could be accessed in two places in the home, however, they were erratically completed. Some people did not have pre-admission assessment records or any risk assessments. Records were partially person centred insofar that they related to the persons individual health care needs. However, they did not contain adequate information about how best to deal with the person’s individual needs, preferences, mental capacity or to stimulate them to become more active or re-abled where that was possible.

The provider told us that one person had been assessed by the district nurses as requiring two-hourly turns. The provider told us that did not think that they needed these. We asked if a review of that person's health care needs had been requested or completed and we were told that it had not. We discussed this with the provider who assured us that a review of her health needs would be requested, but to date at the time of writing of this report we have not been advised that it has. We have however, subsequently received information from the local authority that this regime is still in place.

Some people had only been with the provider between a couple of weeks and couple of months and so had not, for the most part, needed reviewing. We did see that incident reports and daily notes had been made. We looked at 31 records of incidents, in all. In many cases, these documented where errors had occurred regarding medication, falls or missed appointments due to shortage of staff. There were no corresponding reviews or action plans to address these areas of concern. The people who were involved in these instances, in the main, had not been affected by them, although we noted that one person had a fall, possibly as a result of missed medication.

There was no evidence that people or their relatives had been involved in their assessment and care planning process.

We saw that the complaints process and policy had been one which was written for one of the providers other homes but this had not been customised for Hilbre Manor. There had been no complaints recorded.

Requires improvement

Is the service well-led?

Our findings

One person, who lived in the home, told us "If it was run properly, then perhaps it would be good".

On the second day of our inspection, when the new manager was present, a staff member told us that there were, "Huge gaps in the recording, but none since the new manager was here".

On 21 September 2015, we had been told about information of concern, relating to medication errors, staffing concerns and safety issues. This had triggered this inspection. These concerns dated from the beginning of the service, in July 2015 and only after we had received this information and discussed it with one of the previous managers, were the required statutory notifications made to CQC. Statutory notification are required where there are safeguarding concerns or allegations and where other serious events have occurred which affect people using services. They need to be notified to CQC, 'without delay'. This had not happened at the times of the incidents.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents.

The home was newly registered and required a registered manager. At the time of our planning the inspection, the registered managers who shared the post, resigned. A new manager had been appointed, but was yet to formally to take up their new post and register with the CQC, although they were present during both days of our inspection. We have since found that this person had also resigned shortly after our inspection.

At the time of our inspection, it was difficult to determine whether the culture of the organisation within Hilbre Manor was open and transparent. Records indicated to us that there were problems between the previous management of the home and the provider. These had not been addressed adequately prior to our inspection.

The culture of the home was difficult to discern. It was intended to provide support and accommodation for people with dementia and yet had not been designed to enable those people to either navigate the home, or contribute to its running.

We saw that records had been made on the IT system, indicated that there had been previous issues which had not been addressed, or that entries had been altered. This caused us to doubt the values and vision of the home and the provider.

The provider told us that they were developing a new business model which would 'franchise' the homes to others, whilst they remained within Hilbre Care Ltd. This newly registered home, we were told by the provider, was intended to be the first home to be franchised. The provider told us that as a result they had left the two new managers to make their own business decisions, manage and run the home and complete the administration of it. However, as a provider, ultimate responsibility for issues, events, concerns and plans, rest with them.

People told us they liked the home and the staff, but also expressed concern about its future.

The policies, procedures and other documentation were imported from the provider's other homes and had not been customised to meet the needs of Hilbre Manor.

There were no on-going audits relating to the quality and safety of the service and this meant that the service's practice was not questioned appropriately. Records were incomplete and not readily accessible.

There was no evidence of partnership working or of a culture of collaboration and engagement with other agencies, or people and their families.

These examples are breaches of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not cared for in a safe environment, they did not have appropriate risk assessments completed and safe medication storage, recording and procedures were not followed. Care records were not person centred or accurate and were not reviewed appropriately. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not assessed appropriately in relation to their mental capacity and the appropriate best interests meetings or DoLS had not been completed. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that correct procedures had been followed. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective governance, systems or procedures to ensure quality of service.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents CQC had not been notified 'without delay' of incidents such as medication errors. Regulation 18.