Community Integrated Care

West View Short Term Break Service

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was unannounced on 2 June 2016. There were three people staying at the home in the morning of the inspection. One person returned home that day.

West View Short Term Break Service is a short stay respite care home without nursing for up to three people with learning disabilities. 15 people used the service and they were all funded by the local authority. The 15 people had planned short breaks through the year. Some of the people who use the service have complex learning and physical disabilities. They may also have different ways of communicating or making their needs known.

There was not a registered manager at the service. The manager had been in post since January 2016 and was in the process of applying for their registration. 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.

We inspected West View Short Term Break Service in April 2013 and did not identify any concerns. At this inspection we identified five breaches in the regulations and other areas for improvement.

We identified serious shortfalls in people's medicines management and this placed people at risk of not receiving their medicines as prescribed. The storage and recording of medicines were not safe. The manager took immediate action in response to our feedback about the safety of people's medicines. However, this did not mitigate the risks to other people who used the service and the shortfalls were remained a serious concern.
Any risks to people's safety were not consistently assessed and managed to minimise the risks to them. People particularly at risk were those people with complex needs. In addition, some people were placed at risk of infection because of the lack of infection control systems in place for sterilising specialist feeding equipment. This was a breach of the regulations.

People's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. Staff did not always follow care plans that were in place for some people. These shortfalls were a breach of the regulations.

Some people were being deprived of their liberty unlawfully. This was because no Deprivation of Liberty Safeguards (DoLS) applications had been made. This was a breach of the regulations. The manager took action and applied for authorisations for the people who were next due for stays at the home.

Staff still did not fully understand or adhere to the principles of the Mental Capacity act 2005. This was because people's capacity had not been assessed or any decisions recorded that were in people's best interests. This was a breach of the regulations.

The home had not been well led following changes and uncertainty in the management at the home. The provider's systems in place for assessing and monitoring the quality and safety of the service were not effective. This was because the shortfalls we found had not been identified and acted on by the provider. The improvement plan that was in place was not effective and did not mitigate the risks to people's safety and well-being. There were multiple shortfalls in the records kept about people and this meant we could not be sure about the safety and quality of the care and support being provided. These serious shortfalls were a breach of the regulations.

There was a very stable staff group who knew people well and have supported them over many years. Staff were very kind and caring but had not benefitted from any consistent leadership or management over the last two years.

Staff had not received the formal one to one support sessions or annual appraisals they needed. Plans were in place for staff to have formal support sessions. The lack of staff having annual appraisals was an area for improvement.

Staff received core training and some specialist training so they had the skills and knowledge to meet people's needs. Staff were recruited safely.

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, 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.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

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

People were not kept safe at the home this was because the management, storage and administration of medicines were not always safe.

Risks to people were not managed to make sure they received the correct care they needed. This included infection control systems.

Staff were recruited safely and there were enough staff to meet people's needs.

Staff knew how to report any allegations of abuse.

Is the service effective?

Requires Improvement

The service was effective but some improvements were needed.

People's rights were not effectively protected because staff did not understand or adhere to the Mental Capacity Act 2005. Some people were deprived of their liberty unlawfully.

People had access to healthcare as needed during their stays.

People were offered a choice of food and drinks.

Staff had effective core training to carry out their roles. There was a training plan in place.

Is the service caring?

Good

Staff were caring and committed to the people they cared for. Staff did not consistently use terminology that acknowledged they were adults.

Staff were aware of people's preferences and respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive to people and their needs and

needed to be improved.

People's care plans were not always updated and did not include sufficient information about their care and support needs. This meant staff did not have up to date information about how to care for people.

Information about complaints was displayed.

Is the service well-led?

Inadequate

The home was not well-led.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

The culture at the home was reactive rather than proactive.

There were shortfalls in the records kept and they were not accurate.

West View Short Term Break Service

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 2 June 2016 and was unannounced. The inspection was conducted by one inspector.

We met and spoke with the three people staying at the home. One of the people we met had complex ways of communicating and were not able to tell us their experiences of the service. We observed staff supporting people. We also spoke with the manager, the deputy manager, two support workers and an agency worker.

We looked at three people's care and support records and records about how the service was managed. This included two staffing recruitment records, medicine records, audits, meeting minutes and quality assurance records.

Before the inspection, 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 also looked at incidents that they had notified us about. We also contacted commissioners and health and social care professionals who work with people using the service to obtain their views.

Following the inspection, the manager sent us information about the immediate actions they had taken following our feedback, the improvement plan, policies, the staff training and the training plan.

Inadequate

Is the service safe?

Our findings

Two people told us they liked being at the home and we saw that all three people were comfortable and relaxed with staff.

Staff had received training in keeping adults safe. Refresher training was booked for the three staff who had last received training in 2013. The manager had cooperated fully with the local authority during any safeguarding investigations. However, actions and learning from safeguarding incidents were not fully implemented. For example, at safeguarding meetings in January and May 2016 concerns were raised in relation to the accurate completion of body maps. In the May 2016 safeguarding meeting the manager gave a commitment to the local authority safeguarding team that in future the level of detail on people's body maps would be increased. However, this had not happened for the three people staying at the home during the inspection. This meant there was not an accurate record of their skin state on their admission and discharge from the home. Any potential marks or injuries had not been recorded so staff could monitor people's skin and take any action needed.

There had been multiple medicines errors at the home over the previous months. These were notified to us by the 111 service. There was also a recent concern when one person did not receive their medicines because there was not a medicines trained member of staff on duty. People did not come to any significant or lasting harm as a result of the medicine errors.

One person told us they applied some of their prescribed creams and they showed us where they applied them. They told us staff gave them the "small tablets". However, there was not any medicines self-assessment completed for the person's cream application or any PRN 'as needed' plans for any of their 'as needed' medicines. This meant staff did not have clear instructions as to when they needed to administer these 'as needed' medicines. In addition, one of the person's MAR (Medicine Administration Record) was blank apart from listing the prescribed medicines and creams. The MAR did not include the person's name or any of the required personal information. The person's prescribed toothpaste was also not recorded on the person's MAR sheet. The person did not have a medicines care plan detailing how they took their medicines and the support they required. These shortfalls placed them at risk of not receiving their medicines as prescribed.

This person's medicines cabinet was not secured to the wall and was loose on their chest of drawers. This meant the cabinet and the medicines could easily be removed and this did not ensure their safe storage.

The manager took immediate action in response to the above shortfalls we identified including securing the medicines cabinet to the wall and sending us copies of the person's assessments and medicines plans that they completed following the inspection. However, this did not mitigate the risks to other people who used the service and the shortfalls were remained a serious concern.

A second person's liquid medicines were administered in a fizzy drink. There was a record of a telephone conversation with the person's GP. However, there was not a record of consultation with a pharmacist to

check whether it was safe to mix the medicines with the fizzy drink. This meant consideration had not been given as to whether this practice affected the effectiveness of the person's medicines.

Staff signed the person's MAR sheets to show they administered the medicines. However, for two of the three people staying at the home staff had not completed a new MAR sheet for the month of June 2016.

In response to the multiple medicines errors staff had been retrained and their competency to administer medicines was being reassessed. However, as identified there were serious shortfalls in the management medicines at the home. This placed people at risk of harm because there were not safe systems in place for the administration, storage and recording of medicines. This was because although action had been taken for one person there were 14 other people who used the service and the systems in place needed to be robust for all of the people using the service.

Risks to people were not fully assessed and management plans were not in place for all areas of risk. For example, there was not a positive behaviour management plan in place for one person who could sometimes become upset and frustrated. In addition this person's records included and we saw that they sometimes needed to hold onto staff's arm to walk longer distances and they were unsteady when walking up the stairs. However, there was not any risk assessments or risk management plans in place in relation to the person using the stairs.

Another person had epilepsy and there was a plan in place to call paramedics after five minutes if the person had a seizure. However, there was not any description of how the person presented when they were having a seizure. The person's seizures were infrequent and staff did not have the information they needed to recognise and respond appropriately when the person was having a seizure. The staff had been concerned about the person's 'shaking more than usual' the previous day and they had used a listening monitor in the person's bedroom overnight. The use of this monitor overnight was not risk assessed or any subsequent risk management plan put in place to ensure the safety of the person overnight. This was particularly important because there were only 'sleep in' staff employed for the night shifts.

Most areas of the home were clean. However, one of the ensuite shower rooms flooring had dark staining on it. In one of the kitchen cupboards there were loose percutaneous endoscopic gastrostomy (PEG) tubes and syringes. A PEG allows nutrition, fluids and/or medications to be put directly into the stomach. We looked at the records and plans for the person who the PEG equipment belonged to and who had frequent short stays at the home. There was no guidance or risk management plans about how to sterilise this equipment prior to staff using the syringes and tubes to administer the person's medicines through their PEG. This placed this person at risk of infection and harm. The manager told us they had seen staff sterilising the person's equipment prior to administering any medicines of nutrition through the PEG. However, there were not any records or guidance to support this.

A bottle of alcohol gel was in one person's unlocked bathroom cabinet. There was a risk that this alcohol could be ingested by someone as it was not securely stored. The manager took immediate action and removed the alcohol gel. The day to day practices at the home had not identified this risk to people and there were not systems in place to regularly check the contents of unlocked bathroom cabinets.

The wooden boiler pipework cover had nails sticking out from it and was on the kitchen floor where people could have tripped or injured themselves. We pointed this out to the manager who arranged for the cover to be refitted following the inspection.

These shortfalls in medicines management, risk management and infection control were a breach of

Regulation 12 (1) (2) (a)(b)(d)(g)(h).

The manager told us that the staffing levels were planned depending on the needs of the people having short stays at the home. For example, during the inspection there were three people staying and two staff were on duty to support them. During the day when two of the people went to day services one member of agency staff supported the other person.

There was a small stable staff team of five support workers at the home. Agency staff were sometimes used to support some people during the day if the person did not attend any formal day services.

We reviewed two staff recruitment records. Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. These checks included the use of application forms, an interview, reference checks and criminal record checks. This made sure that people were protected as far as possible from staff who were known to be unsuitable.

There were systems in place for the maintenance and monitoring of the building and equipment. This included the servicing of boilers, hoists, equipment and a legionella risk management plan.

Requires Improvement

Is the service effective?

Our findings

Staff told us they had not had any one to one support sessions but that these were now planned. We saw in records one staff member had received a support session two weeks before the inspection. This was because there had been changes of managers and a senior support worker at the home over the last year. This was confirmed by the manager. Staff had also not had any appraisals. It is recommended staff have annual appraisals.

A new senior support worker had started work at the home the previous month. The manager told us there was an induction, training and development plan in place for this staff member and this included a manager's course. This was because it was planned that the senior support worker would be managing the home on a day to day basis.

The manager sent us the training summary for the staff. Staff had received training in moving and handling, medicines management, safeguarding and positive behaviour support training. Staff completed electronic learning for food safety, fire safety and infection control. First aid, Mental Capacity Act 2005 (MCA), Deprivation of Liberty safeguards (DoLS), Epilepsy and safeguarding training was booked for all staff. Named staff had been trained in the PEGs and the administration of specific invasive medicines.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. This applies to short stay services as well.

We checked whether the service was working within the principles of the MCA. No applications had been made to deprive people of their liberty whilst staying at the home. This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were being deprived of their liberty without lawful authority.

Following the inspection the manager made applications to the authorising body for the two people who were due to have stays at the home the next week.

Some people who stayed at the home because of their learning disabilities may not have had the mental capacity to make specific decisions. There were no mental capacity assessments or any subsequent best interest decisions recorded for any of the four people whose records we reviewed. For example, one person's medicines were mixed with drinks, a listening monitor was used and a lap belt was used to safely restrict their movement whilst they were in their wheelchair. Staff told us another person used bedrails during their stays at the home. There were no mental capacity assessments or best interest decisions in place for these decisions.

These shortfalls of acting in accordance with the Mental Capacity Act 2005 were a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff sought consent from people before care and support was provided. One person told us staff asked them if they wanted help before they gave it to them.

People were involved where appropriate in the preparation of their food. One person was able to help themselves to food and drinks from the kitchen. Two people told us they liked the food they had when staying at the home. One person's food preferences were recorded in their care records.

The guidelines for people on specialist diets were displayed on the kitchen notice board so staff had easy access to the information. These guidelines were supported by pictures to make them easier to understand. However, this meant that all of the people who used the kitchen could also see this personal information about others. This was an area for improvement to improve and maintain people's confidential information.

People remained registered with their own GP's during their stay. Staff contact people's GP's or 111 service if there were any concerns during people's stays.

Good

Is the service caring?

Our findings

Two people who were able to told us staff were kind and caring. One person said, "I like them" and another said "They're nice". The third person laughed and smiled at staff. They gave them eye contact and reached out for them. This showed they were comfortable with the staff.

Staff showed a caring attitude towards people and recognised and knew them as individuals. Staff spoke fondly about people and the things they liked to do whilst during their stays. Staff told us they enjoyed working with people and that they had worked with them for many years.

Some staff did use some terminology when they we speaking with one person that did not respect that they were an adult. The terminology was said in a kind and caring way. However, it is recommended that staff use people's preferred names or terminology that reflects they are an adult.

Staff respected people's privacy. They knocked on people's doors and asked their permission before going in. One person chose to spend some time alone in their bedroom and staff respected this.

Staff involved people in making decisions about the care and support they required whilst staying at the home. For example, staff asked one person whether they wanted their support to shave. The person accepted this support because their shaver had not been charging properly. Staff also offered another person a visual choice of breakfast. This was because the person did not communicate verbally. Staff told us they knew the person did not eat breakfast when they were at home but said they liked to offer them breakfast whilst they were at the home just in case they wanted a change.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were out of date and did not include sufficient information so staff could provide the care and support people needed.

One person told me one of their relatives had died. However, this important information had not been updated in their care plan and their 'circle of support' document. Circles of support are a group of family, friends and supportive workers who come together to give support and friendship to a person. This person's care plan had a care plan summary that had been completed in 2013. The records did not include how staff were to support them when they were upset, what support they needed with their medicines, whether they had epilepsy and how this presented (they were prescribed medicines for epilepsy) and the plan did not detail what support they needed with their personal care. The person used single words or short sentences to communicate but there was not a communication plan in place to assist staff to understand this person's communication. We saw the person became frustrated when agency staff did not understand what they were saying.

A second person did have a care plan in place but this lacked detail and had not been reviewed since 2013. For example, The person had complex ways of communicating and communicated using sounds and gestures. However, the communication plan in place was dated 2004 and had not been reviewed to see whether the person's communication had developed or changed. Their care plan also made references to staff needing to support the person to use the toilet. The care plan did not detail how often staff should do this and whether the person was able to use the toilet. Staff had recorded in daily records when the person had passed urine or had their bowels opened but they did not include details as to whether the person had used the toilet or whether they had been to the toilet in their incontinence wear. The person's care plan detailed they preferred a bath in the evening. However, their records did not detail whether this care had been provided every evening during their stay. We reviewed the bath temperature records and there was only one record of bath temperatures being tested the evening before the inspection. This meant we could not be sure the person had received a bath as detailed in their care plan.

This person's care plan was written in 2013 and had not been reviewed. This person came to stay at the home for up to six weeks a year. This person needed support with all aspects of their personal care, communication, preparing food, moving and positioning and their emotional wellbeing.

The care plan for third person who had complex needs and who needed support for all aspects of their personal care, nutrition and mobility did not include sufficient detail for staff to be able to provide them with the care and support they needed. For example, there was not a clear care plan in relation to PEG and how to staff were to care for the PEG, the site or what they needed to record to demonstrate that this care had been provided.
Information in a fourth person's care plan was incorrect because the care plan had not been updated and reviewed to show what days they attended their day service.

Staff were knowledgeable about people and their needs and what they enjoyed doing. However, the care

plans included little information about how people wanted to spend their time whilst at the home when they weren't at planned day services.

These shortfalls in people's needs being fully assessed and planned for was a breach of Regulation 9 (1)(a)(b)(c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were occupied during the inspection. For example, one person went out to feed the ducks and buy a book with an agency member of staff. Another person was given tactile balls and crinkly bags to hold and rub. They visibly enjoyed this and smiled and laughed whilst doing this. Another person was listening to their radio in their bedroom until it was time to go to their day service.

The manager told us the home had been responsive to people who had needed a short stay placement at short notice. This was supported by information shared by the local learning disability team.

The provider had a written and pictorial complaints procedure displayed. We reviewed the complaints file and there were not any recorded complaints for the last year. There was a system in place for reviewing complaints and compliments.

Inadequate

Is the service well-led?

Our findings

There has not been a registered manager at the service for over a year. The new manager started in January 2016 and is applying to be registered with the Commission. They are responsible for managing four services in the locality. In addition a senior support worker had been appointed who would have day to day responsibility for the home. The senior started work at the home the month before the inspection.

The local authority contract monitoring team visited the service in August 2015 and identified multiple shortfalls similar to those identified at this inspection. An improvement plan was put in place but the actions identified in the improvement plan had not been fully met when the local authority visited in January 2016.

The last medicines audit completed was in May 2015. Although some medicines errors had been identified there was not a consistent way of auditing and reviewing whether people were receiving their medicines as prescribed.

The manager sent us the provider's audit tool they had completed in May 2016. This included auditing two of the people's care records we also reviewed and the other management systems in place at the home. This audit identified some shortfalls, for example, people's risk assessments needed to be reviewed or put in place, monthly auditing had not been completed and complaints recording needed to improve. Not all of the areas for improvement had actions identified and some actions such as updating risk assessments had not been completed by the timescales set by the manager.
People's care plans had not been reviewed and updated as their needs changed. Some elements of people's care plans had not been updated or reviewed since 2013.

The management of the service was reactive rather than proactive. The manager took action in response to the shortfalls we identified. However, these shortfalls should have been identified in the provider's governance systems and acted upon when they were identified.

As detailed throughout the report the provider's governance systems in place failed to assess the safety and quality of the service for people, fully identify areas for improvement and to take action to address those areas that had not been effective.
We identified multiple records shortfalls. For example, there was daily handover record that prompted staff to check and sign if their colleague had administered people's medicines as prescribed. We saw these records were inconsistently completed which meant this checking system was not effective in identifying shortfalls.

Body maps for people were not consistently completed on people's admission or reviewed during their stay. In addition, body maps were not completed prior to people's discharge from the service so there was a clear record of people's skin before returning home. This was important to show if people developed any skin injuries during their stay. For example, one person had a body map completed on their admission that showed that their skin was clear. Information had been given to staff by the person's transport driver that the person had fallen and landed on their buttocks before arriving for their stay. However, the body map or

the person's skin was not reviewed during their stay and prior to their discharge to see whether they had developed any marks or injuries from the fall. This person did not communicate verbally and may not have been able to alert staff to any injuries.

Another person had not had a body map completed since 2015. A third person's body map was only part completed. The importance of completing body maps accurately had been identified previously as a result of safeguarding investigation.

In two people's records two separate incidents were recorded on loose pieces of paper and not on the provider's recording templates. One of these incidents related to an incorrect pharmacy label on one person's medicines. This incident was also not recorded on the provider's incident reporting system as detailed in their policy. This meant that these incidents were then not included in their electronic incident monitoring systems.

Shower temperatures were not recorded on the documents in people's bathroom to ensure that the temperatures were safe.

The systems for monitoring, labelling and dating foods in the fridge were inconsistent. For example, there was a half a packet of bacon in a bag that did not have a date of opening. There was a tray or yoghurts that had a use by date the same day of the inspection. It was not clear what the systems were for checking and removing foods that were out of date or going out of date in the fridge.

These shortfalls in the governance and record keeping were a repeated breach of Regulation 17 (1)(2)(a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us there was an open culture and atmosphere where they felt able to raise concerns with the manager. They told us they had a staff meeting a few weeks before the inspection but that they had not any prior to this for a long time. This was confirmed by the manager.

Staff knew how to whistleblow and the provider had systems in place to support staff to do this.

The manager told us they were currently sending surveys to people who used the service and their families.

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 There were shortfalls in the assessment of people's care and support needs and preferences. People's care and support was not designed to meet their needs and preferences. The care and support was not appropriate and did not always meet the needs of people or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person. This was because where a person was unable to give consent the provider had not acted in accordance with the MCA 2005.

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 People were being deprived of their liberty without lawfully authority.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way. This was because there were serious shortfalls in the safe management of medicines, the risks to people were not assessed and mitigated and infection control risks were not managed.

The enforcement action we took:

We issued a warning notice and the provider was required to be compliant with the regulation by 1 July 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes for assessing, monitoring and mitigating the risk to people's health, safety and welfare were not effective. There were not effective systems for assessing, monitoring and improving the quality and safety of service provided to people. There were shortfalls in the accurate, complete and contemporaneous records for people.

The enforcement action we took:

We issued a warning notice and the provider was required to be compliant with the regulation by 2 September 2016