Richan Care (Midlands) Limited

Five Rivers Living Residential 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**

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.
About the service

Five Rivers Living Residential Home is a residential care home providing personal care to up to 50 people. The service provides support to elderly people and people living with dementia and/or learning disabilities. At the time of our inspection there were 32 people using the service.

People's experience of using this service and what we found

Right Support: People's needs were not always assessed appropriately, and care plans did not always reflect people's needs. People were not always supported by well trained staff.

The service felt clinical and lacked homeliness, as there was a lack of personalisation and decoration. People with specialist diets received food and drink appropriate for their needs. Records indicated health care professionals visited the service regularly.

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

Right Care: People were not always protected from risk of falls. Staff did not have access to guidance on how to evacuate people safely in the event of an emergency. People did not always have access to a call bell to seek staff attention and were not always kept safe from the risk of developing pressure related injuries.

Infection prevention and control was sometimes lacking, and service cleanliness was poor. People were not always supported by enough staff and there was a reliance on agency staff to fulfil staffing requirements. Medicines were administered safely, and records were well maintained and up to date.

There was a lack of available guidance for staff in relation to end of life care, and people were not always treated with dignity and respect. We have made a recommendation the provider review staff training and monitoring in relation to providing dignified care.

Right Culture: Quality assurance systems and service oversight was not always effective. The provider was in breach of their regulatory conditions. The registered manager and provider were open and honest during

our inspection and had knowledge of their legal responsibilities in relation to duty of candour.

People's care plans did not always reflect care provided. Emotional support interventions were not always being recorded by staff. People's communication needs were not always met effectively.

There was a lack of activities available for people, and there was a lack of meaningful engagement from staff. People were at risk of social isolation.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for the service under the previous provider was Inadequate (published on 7 March 2023).

Why we inspected
The inspection was prompted in part due to concerns received about medicines and quality of care. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. The provider took some action during the inspection to mitigate the most immediate risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Five Rivers Living Residential Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to personalised care, dignity, safe care and treatment, environment and equipment, governance and staffing, at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Five Rivers Living Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was completed by 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Five Rivers Living Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Five Rivers Living Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We visited the service on 2 separate days to complete the inspection. We checked the environment on each site visit. We spoke with 12 people living at the service and 4 relatives, to gain feedback on their experiences of using 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. We spoke with 10 staff including the area manager, registered manager, and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a selection of records for 14 people including care plans, risk assessments, capacity assessments, medicine records, daily notes, and other monitoring charts and records. We looked at 8 staff files in relation to recruitment and reviewed the providers training and supervision monitoring documents. A variety of records relating to the management of the service including, quality checks, policy and procedures, incident reporting and health and safety were examined.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People were not always protected from the potential risk of falls. One person who required monitoring by staff to ensure they mobilised safely, was left unattended. We raised this with the provider, and they took immediate action to mitigate the risk of falls.
- People did not always have access to a call bell to seek staff attention. One person told us, "I had a panic buzzer but it's gone, I need another one." Another person told us, "I can wait a long time sometimes. I don't have a buzzer in my bedroom." This put people at risk as they were unable to call for assistance in the event of an emergency. We raised this with the provider, and they stated they were in the process of making repairs to their call bell system, and temporary monitoring was in place to reduce the immediate risk.
- Staff did not always have access to sufficient guidance on how to evacuate people in the event of an emergency. Person Emergency Evacuation Plans (PEEPs) were in place, but they sometimes lacked essential information about people's abilities and support needs to ensure safe evacuation.
- People were not always kept safe from the risk of developing pressure related injuries. People who were at risk of developing injuries were not always repositioned as frequently as required. We raised this the provider, and they took immediate action to ensure staff were aware of this risk and people's needs were met.
- Incidents were not always well managed. Incidents and injuries were not always recorded or reported. This meant people were not always kept safe from the risk of harm.

Preventing and controlling infection

- We were not assured that the provider was preventing visitors from catching and spreading infections or promoting safety through the layout and hygiene practices of the premises. The service was visibly unclean in both people's private rooms and shared living areas.
- We were not assured that the provider was supporting people living at the service to minimise the spread of infection, or ensuring PPE was used effectively and safely. We observed staff not wearing an apron or any protective equipment when supporting a person with their meal. This presented a risk of cross contamination and increased the risk of the spread of infectious diseases.
- We were not assured that the provider was responding effectively to risks and signs of infection. We found a used and dirty dressing left in a person's bathroom within their toiletry items. We found 1 person's toothbrush to be visible dirty.

People were not always protected from the potential risk of harm, and infection prevention and control was not always sufficient. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Service cleanliness was lacking. For example, dead insects, dust and dirt were found in corridors and communal areas. Some lounge chairs harboured large amounts of debris and crumbs, and floors were sometimes sticky.
● Equipment was not always kept clean. People's wheelchairs were visible dirty including arm rests, foot plates, wheels and seats. Some of this dirt appeared to be engrained and longstanding.
● Unpleasant odours were observed in people's private rooms, and communal areas of the service. We found 1 person's bedding to have a very strong odour of urine, despite staff having changed the sheets and made the bed. Some pressure relieving cushions were also very dirty and had very strong unpleasant odours.

Service cleanliness was poor, equipment was not kept clean, and unpleasant odours were observed. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured that the provider was admitting people safely to the service.

Staffing and recruitment
● People were not always supported by enough staff. We observed people sometimes having to wait for prolonged periods for staff to become available. One person told us, "I wait for a shower and it can be a long time." Another person told us, "I have to wait too long; it's boring sitting here."
● The staff on shift during our inspection were often very busy and had little time for meaningful interaction with people.
● Rotas indicated the service frequently relied on agency staff to fulfil their staffing requirements. One staff member told us, "We have agency more or less every shift, and in my opinion, this is what is bringing the service down." The provider acknowledged they were using a high amount of agency staff but where possible they were using the same agency staff to promote continuity of care.
● There were insufficient housekeeping staff to maintain service cleanliness. Staffing rotas indicated there was only one housekeeper on shift per day, and some days, there was no housekeeper on shift. Records indicated some cleaning tasks were distributed to other staff members. However, we found service cleanliness to be lacking.

Insufficient staffing was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We raised concerns regarding staffing with the provider, and they told us they were in the process of recruiting new team members.
● Staff employment histories were not always obtained and gaps in employment histories were not always explained.
● The provider obtained employment references to ensure staff had the necessary experience.
● Safe recruitment checks were in place such as DBS checks: Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected by an effective safeguarding process. A system was in place for recording and reporting safeguarding concerns. However, poor injury and incident recording undermined this process, and the provider could not be assured people were fully protected from the risk of improper treatment and/or abuse.

● Staff were trained in safeguarding and understood how to identify and raise concerns.

Using medicines safely

● We received mixed feedback from people using the service about the support they received with their medicines. One person told us, "They look after my medication; they are for my heart and blood pressure." Another person told us, "They turned up at 9.30 today for medication, it used to be 7.30. They chose the times."

● We observed staff administering people's medicines safely.

● Records were well maintained and up to date, supporting safe medicine practices.

● People's care plans contained information regarding their medicines support needs, and risk assessments detailed any specific risks related to the use of certain medicines.

Visiting in care homes

The provider facilitated visitations at the service from health professionals and people's friends and families, in accordance with government guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- There were significant gaps staff training records. For example, many staff had not completed training on personal care, eating disorders or end of life care. This meant people were not always supported by staff who had the required skills and training to meet their needs safely and effectively.
- Staff received 1:1 supervision for support and professional development. However, records indicated these were not always completed in a timely way and in line with the provider's policy.
- Staff performance was not always monitored effectively. The registered manager and the provider completed observations of staff performance. However, this was not always effective, as we found staff engagement with people to be lacking and there was a lack of dignified care.

Staff lacked required training to meet people's needs and performance management was not always effective. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- New staff completed an induction and The Care Certificate as part of their training. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not always assessed appropriately. For example, falls risk assessments did not always accurately reflect people's falls histories, identify appropriate levels of risk based on people's needs, or indicate mitigation measures in place to reduce risk. This meant falls risk assessments were not effective.
- Personalised care plans were in place, but these were not always kept updated and did not always reflect people's needs. For example, information on how to support people with their religious beliefs was lacking and did not always reflect the daily support provided. This meant the provider could not be assured people's religious needs were adequately met.

Adapting service, design, decoration to meet people's needs; Supporting people to eat and drink enough to maintain a balanced diet

- The service felt clinical and lacked homeliness. People's private rooms and communal areas lacked personalisation. One relative told us, "It's not homely if you know what I mean."
- People were mostly supported to drink enough. However, records indicated people's fluid consumption

sometimes varied significantly, and there were no records to explain these variations. We also found 1 person to be without access to fluids. This meant the provider could not always be assured people received consistent support with drinks.
● People were supported to eat enough, and the food provided looked and smelt appetising. One person told us, "The food is fantastic."
● People with specialist diets and eating requirements received food and drink prepared appropriately for their needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● When people's needs changed, referrals to specialists were completed. However, these referrals were not always completed in a timely way and people's records were not aways well maintained to document these referrals.
● The provider worked with health and social care professionals to ensure people received the care they needed.
● Records indicated health care professionals visited the service regularly.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Deprivation of Liberty Safeguard's (DoLS) were in place when people were deprived of their liberty due to requirements of their care needs. Conditions of people's DoLS were met and considered in their care plans.
● Where people lacked capacity to make decisions regarding their care, assessments were in place. Mental capacity assessments were detailed and considered people's needs, personal wishes and best interests.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- Staff did not always promote dignity and respect when supporting people with their meals. We observed staff supporting people with their meals in complete silence. There was no verbal communication to tell the person what they were doing or what they were eating or drinking. We also observed staff supporting 1 person with their meal without clearing their chin of excess food and saliva. This was not dignified care.
- Records indicated that people did not always receive support with oral care. This lack of consistency meant people's needs were not always met.
- There was a lack of guidance available for staff in relation to people receiving end of life care. There was no care plan in place for 1 person receiving end of life care. This meant staff did not have guidance on how to ensure they received dignified care respecting their personal choices and wishes.
- People did not always receive respectful and dignified care when supported with their mobility. For example, we observed staff supporting 1 person to transfer with a hoist in complete silence. Staff did not provide verbal reassurance to the person.

People were not always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We received mixed feedback about staff. One person told us, "There is no dignity because the staff talk to each other in their own language. Some staff don't use their initiative." However, one relative told us, "The staff are really very nice, they are looking after [relative]. The staff are lovely with [relative], they have a lot of patience."
- Staff spoke fondly about the people they supported and the service. They indicated the provider was making improvements at the service and was caring.

We recommend the provider consider current guidance on delivering dignified care, and review the effectiveness of their staff training and monitoring procedures to drive improvements in this area.

Supporting people to express their views and be involved in making decisions about their care

- Channels were in place to enable people the opportunity to provide feedback about their care. However, during our discussions with people and their relatives, concerns were expressed to us that had not been raised with the provider. A review of the provider's procedures indicated more could have been done to seek the views of people and their relatives regarding people's care and service provisions.

● Care plans and other documents indicated people were consulted about their care. However, people did not always have awareness or access to these records.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People were not always aware of or had access to their care plans. One person said, "I don't have a care plan, they are going to give me one." Another person told us, "I do not have a care plan because I look after myself." A third person also told us they did not have a care plan. This meant the provider could not be assured care plans were personalised and relevant to people's needs and wishes.
- People's care plans did not always reflect care provided. For example, we observed the use of distraction techniques for 1 person that were not detailed in their care plan.
- Emotional support interventions were not always being recorded by staff, as detailed in a person's care plan. This meant the provider could not ensure support remained personalised and appropriate for their needs.
- Picture based communication cards were not always used effectively. We observed staff not using communication cards appropriately or in accordance with a person's care plan. There were also no communication cards available for some of the person's care needs, such as medicines. This meant the person's communication needs were not always met effectively.

Care was not always personalised to people's needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was a lack of meaningful engagement from staff. We observed minimal interactions between staff and people. Staff were very busy and didn't appear to have time to sit and speak with people.
- There was a lack of activities available for people. One person told us, "It gets boring as there is now't (nothing) to do." One Relative told us, "I'm just not sure about the interaction during the day, I'm worried there may not be enough opportunity for [relative] to engage in activities." One staff member said, "We should have more time for activities." We raised this with the provider who told us they were in the process of employing a new activities co-ordinator to support with activity engagement.

● People were at risk of social isolation. We found people to be alone in their rooms without the means to call for assistance. One person told us, "I am frightened of being alone too much." One relative told us, "I'm worried there may not be enough interaction from staff."

End of life care and support

● As reported in key question caring, there were no care plans in place for 1 person who was receiving end of life care. This meant staff did not have access to essential guidance on how to support this person with dignity and respect, and in accordance with their wishes. We raised these concerns with the provider, and they promptly implemented a care plan for this person.

● Staff had not received training on end of life care. This meant the provider could not be assured staff had the necessary skills to ensure safe and dignified end of life care.

Improving care quality in response to complaints or concerns

● An effective system was in place to record and monitor complaints.

● Records indicated complaints were responded to and follow up actions were completed.

● People and their relatives told us they felt comfortable raising complaints. However, we identified people had concerns they had not raised with the provider. This indicated a lack of opportunity to provide feedback on care.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Quality assurance systems were not always effective. For example, there was no audit process in place to ensure care plans were up to date and relevant to people's needs.
- Monitoring systems were not used effectively to ensure service oversight. For example, a monitoring spreadsheet was in place for staff training and competencies. However, we found this data was not always accurate. This prohibited effective oversight.
- Oversight of incidents was not always effective. We found evidence to indicate not all incidents and injuries were recorded. This prevented effective oversight and analysis.
- The provider was in breach of their registration conditions. The provider did not have the necessary service specialisms included within their regulatory registration to meet the services provided to people at the time of our inspection. Consequently, they were in breach of their conditions. We raised this with the provider, who submitted a new application and rectified the breach.

Continuous learning and improving care; Working in partnership with others

- Quality assurance and provider oversight processes did not always identify concerns or risk. This meant opportunities for learning and service improvement were missed.

Quality assurance and service oversight processes were not always effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider engaged with health and social care professionals, and the local authority.
- The provider actively engaged in the inspection process and was mostly open to feedback and recommendations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider and the area manager had significant presence at the service. They engaged regularly with staff and people using the service. This promoted a positive culture at the service.
- The door to the manager's office was open throughout our inspection, only to be closed when confidential conversations took place. We observed staff and people visiting the office frequently.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong
● The provider was open and honest during our inspection.
● The provider and the registered manager had knowledge of their legal responsibilities in relation to duty of candour.
● Where required, the provider notified The Care Quality Commission of events and incidents, in accordance with their regulatory responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Feedback from relatives about the provider and registered manager was mostly positive. One relative told us, "They keep me updated when things are happening at the home like events. I've been happy since day one."
● Staff were positive about the new provider and felt the service was improving. One staff member told us, "Things have massively improved since new provider took over."

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 Care was not always personalised to people's needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 always protected from the potential risk of harm, and infection prevention and control was not always sufficient. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Service cleanliness was poor, equipment was not kept clean, and there were unpleasant odours. This was a breach of regulation 15 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and service oversight processes were not always effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably trained staff. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.