Livability

Livability Bradbury Court

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Livability Bradbury Court is a care home that accommodates up to 21 people across two floors, each of which has separate adapted facilities. At the time of the inspection 20 people lived at the service. People who used the service had physical disabilities, some of whom also had a learning disability. Most people lived there permanently, and some people spent short periods there to receive respite from their main carers.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service was a large home, bigger than most domestic style properties. However. the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
Staff had received training in the safe administration of medicines. However, some staff members were not suitably trained and competent in managing high risk medicines or medicines that had to be administered from original packaging. There were procedures for investigating and learning from accidents. However, we judged there was limited organisational learning because investigations focussed on the errors of individual staff members, with less attention on root causes.

Apart from the shortfalls identified with medicines management, we found people were protected from the risk of harm and abuse. Safeguarding procedures were in place, which staff were aware of. Staff were recruited safely. Even though there were staff shortages, a contingency plan was in place.

People's care records showed relevant health and social care professionals were involved in their care. People receiving care told us staff were competent. However, we noted staff required tailored training to improve their awareness of how to properly administer specific medicines. There were arrangements to ensure people's nutritional needs were met. The home environment was adapted to make it accessible to people who used wheelchairs. One of the two lifts was not working, and there were arrangements for repairs.

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. When people were unable to make decisions about their care and support, the principles of the Mental Capacity Act (2005) were followed.

People's privacy and dignity were respected. Staff protected and respected people's human rights. They had received training in equality and diversity. People's spiritual or cultural wishes were respected. Staff maintained people's independence by supporting them to manage as many aspects of their care as they could. People's privacy was also upheld in the way their information was handled. The service recognised people's rights to privacy and confidentiality.

People told us their needs were met. We observed a range of practices that reflected person centred care. People's values and preferences were respected. Their families were involved in care as appropriate. We also saw people had access to appropriate care and information, which was presented in an accessible way for people to make decisions about their care. This was regularly reviewed to monitor whether care was up to date and reflected people's current needs. We discussed with the registered manager the need to develop more creative ways for people having more control over their own medicines and money.

Although improvements had been made in the monitoring systems, we judged further improvements were required in the way accidents were investigated in order to enhance learning from them.

Rating at last inspection
The last rating for this service was requires improvement (published 25 March 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough, improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about medicines and staffing. 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 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.

Enforcement
We have identified breaches in relation to how certain medicines were managed, and how well accidents were managed.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was 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.

Livability Bradbury Court

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 Care Act 2014.

Inspection team
The inspection team consisted of one inspector, a pharmacist and two Experts 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
Livability Bradbury Court is a care home. People in care homes receive accommodation and personal care. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Prior to the inspection we reviewed information and evidence we already held about this service, which had been collected via our ongoing monitoring of care services. This included notifications sent to us by the service. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. We also viewed the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well and improvements they plan to make. This information helps support our inspections. Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and

local authorities.

During the inspection
We spoke with 13 people who used the service and one relative about their experience of care provided. We spoke with six members of staff including, the registered manager. We reviewed a range of records, including recruitment information and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We received information relating to the provider's governance systems and some care records. This information was used as part of our inspection.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Using medicines safely

• We assessed progress with any areas for improvement identified in our last inspection of January 2019 to determine if people were receiving safe care. There were some examples of good practice in relation to the management of medicines, including storage, disposal, completion of medicine records (MARs), and the administration of most medicines.

• However, we identified areas for further improvement, including management of high-risk medicines such as warfarin (warfarin is an anticoagulant used to thin blood to avoid the risk of stroke or thrombosis), and other medicines that required to be administered from their original packaging.

• The service was experiencing high level of medicines errors. Eight errors had been detected within the last 12 months. Although this had not led to harm of people, the errors indicated a pattern of incidents occurring when medicines were given from original packaging.

• Six out of eight errors were for medicines prescribed to be given from their original packaging. We judged there was a risk of medicines errors because the service did not have a safe process for supporting people where medicines were supplied in original packaging.

• Furthermore, we observed medicine rounds were constantly interrupted because there were not enough measuring pots, which meant staff constantly stopped to wash the pots at the sink. We judged this could potentially result in procedural failures, thereby compromising people's safety.

• Written policies and procedures for the management of medicines were in place but did not have review dates. All procedures relating to medicines should have a review date. They should be reviewed annually, or more often if changes in legislation, evidence, national or local guidance or best practice occur.

The above evidence demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

• Accidents and incidents were monitored. There was a system for managing accidents and incidents to reduce the risk of them reoccurring. There were clear records to show how the service had managed incidents to make improvements to the service. Staff understood their duty to raise concerns and report incidents and near misses.

• That said, we were concerned with how the service was dealing with incidents of medicines errors. These had been investigated and recorded but had not resulted in improvement. We judged systems and processes for dealing with medicines errors were not enabling the service to learn and make improvements.

• A 'person-based approach' was used to investigate incidents. This focussed investigations on the staff

member who had committed the error, who was then offered supervision, retraining, observation and competency checks. We judged this approach made recurrences more likely because consideration was not given to organisational processes and other contributory factors that could have led to errors.

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

Systems and processes to safeguard people from the risk of abuse
• People who used the service were protected from the risk of harm and abuse. One person told us, "I feel safe. If I'm upset I tell someone. I am happy here."
• The service had safeguarding policy and procedures and staff were aware of this. Staff had received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. They were aware they could contact the local authority safeguarding team and Care Quality Commission (CQC) when needed.

Assessing risk, safety monitoring and management
• Risks to people had been identified, assessed and reviewed. These covered a range of areas, including, choking, pressure ulcers, falls, nutrition and hydration and behaviours that challenged the service. There were measures to protect people without unnecessarily restricting their freedoms.

Staffing and recruitment
• Safe recruitment procedures were in place. This included, at least two references, proof of identity and Disclosure and Barring Service checks (DBS) and checks to establish whether the potential member of staff was barred from caring for people.
• The service was experiencing staff shortages. We received mixed feedback from people. Whilst some were content, others expressed concerns. Feedback included, "I think there is enough staff, although sometimes it's a bit short", "There could be more staff in the evenings. Staff are a bit rushed" and "Weekdays are not so bad. At the weekends I could be waiting 10 – 15 minutes for them to answer the doors."
• We observed there was an over-reliance on agency workers. However, we did not see any direct impact on the care people received. Staff had time to respond to calls. One person told us, "I have a call bell within reach. Staff come straight away." There were also enough staff to support people at meal times. There was always at least one member of staff in the dining room.
• The service had a contingency plan in place to respond to staff shortages. They were actively recruiting and there was a team of bank and agency staff to cover gaps in the rota. An on-call system was also in place for emergencies.

Preventing and controlling infection
• The communal areas of the home were all clean and well maintained. There was an infection control policy and measures were in place for infection prevention and control. Staff had completed training in infection control. They wore personal protective equipment (PPE) such as gloves and aprons. Arrangements were in place for managing waste to keep people safe.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now changed to 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
• Staff received support, training, professional development, supervision and appraisal as was necessary to enable them to carry out their duties. Training completed included, nutrition and diet, moving and handling, pressure sore prevention, safeguarding and medicines management.
• New staff had completed an induction programme based on the Care Certificate framework. This is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. They also shadowed experienced members of staff until they felt confident to provide care on their own.
• People told us, "Staff have skills to provide good care. I will tell them if they don't", "Staff are well-trained and experienced to provide care" and "Staff receive good training. They also shadow other staff."
• That said, we raised concerns about the competence of staff to administer certain medicines. Although staff were trained in the handling and use of medicines, and had their competence assessed, this had not been tailored for the specific shortfalls that the service was encountering.

Adapting service, design, decoration to meet people's needs
• Person-centred approaches were used for wheelchair access. Changes (reasonable adjustments), to the environment, had ensured an accessible home environment for people who used wheelchairs. Doorways and hallways were wide. We observed people moving within the home performing functional tasks such as household chores with ease. People told us the environment was accessible. One person said, "I am independent. I can come and go as I please." Another person said, "I know the code to the door. I can go out independently. My life began the day I moved into Bradbury Court."
• The home had two lifts, however, one was not working. The registered manager told us some spare parts were being shipped from Germany. There was a contingency plan in place in case both lifts broke down at the same time.

Supporting people to live healthier lives, access healthcare services and support and working with other agencies to provide consistent, effective, timely care
• People had access to a range of community health and social care professionals when required. Care delivery was co-ordinated with a range of external healthcare professionals which included GPs, speech and language specialists and district nurses.
• People received their annual health checks. An annual health check can improve people's health by spotting problems earlier, so people get the right care.
• Less positively, people with learning disabilities did not have a Health Action Plan (HAP). A HAP contains

actions needed to maintain and improve the health of an individual and any help needed to accomplish this. Although people accessed healthcare services, a HAP could enhance access by serving as a prompt throughout the year for the person with learning disabilities. The registered manager told us she is now seeking advice regarding this

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs had been assessed before they used the service. Their care was tailored to these needs as we observed throughout the inspection. The care plans described step by step, the needs of people, their views, choices and actions by staff to meet those needs.
• People's care mostly followed nationally agreed best practice, particularly as defined by reputable national guidance such as National Institute for Health and Clinical Excellence (NICE) guidance on service delivery. We observed good practice that was consistent with person centred care values. In each example, people's care considered their individual requirements and preferences, including meeting their physical, cultural, spiritual and psychological needs.

Supporting people to eat and drink enough to maintain a balanced diet
• There were arrangements to ensure people's nutritional needs were met. Their care plans considered their individual requirements in relation to nutrition and these were known to staff. In some examples, this was delivered in partnership with relevant healthcare professionals, such as dietitians and speech and language therapists.
• People confirmed their nutritional needs were met. They told us, "The meals are nutritious. I choose what I want to eat. It is quite personal", "There is a menu to choose from. We are on all different diets mainly due to our health needs" and "I have any allergy of certain foods. Staff monitor what I eat."
• We observed lunch time. Food looked well presented, with people provided with an appropriate mix of supervision and assistance as required. Where people had specialised diets by choice or dietary needs, these were catered for.
• People were offered choices. On the day of the inspection, lunch options included quesadilla chicken (season chicken pepper with spices and stir fried filled in tacos wrap in bread), French soup, jacket potato choice fillings and side dishes servers with tomato salsa mixed salad. Equally, dinner options were as appetising and healthy.

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 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. 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• We saw evidence where mental capacity assessments and best interest decision forms had been completed for specific decisions. For example, covert administration took place in the context of the MCA legal provisions. There was evidence of mental capacity assessments, best interest meetings and regular

reviews of whether covert administration was still needed.
• People confirmed they were always asked for their consent before staff proceeded with support, which we observed. They had signed the care records to show that they had consented to their planned care, and terms and conditions of using the service.
• Five people were subject to a DoLS for their safety. People had free access of all areas of the building, which showed they had independence and the freedom to move around with undue restriction on their liberty.

Good

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.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People had access to support and care regardless of their individual circumstances. One person told us, "My religious needs are respected. The service provides me with staff to take me to the temple." Another person said, "I am supported to go to church every Friday."
• There were people from a range of religious backgrounds, including Christianity, Jewish, Islam and Hindu, and staff understood and addressed their religious and cultural needs. People were supported to visit their places of worship.
• The chef had a menu, which was in line with people's cultural or religious needs. For example, there were vegetarian options for people from Hindu background.

Supporting people to express their views and be involved in making decisions about their care
• There were systems and processes to support people to make decisions. As stated, the service complied with the provisions of the MCA 2005, which meant people were involved in making decisions about their care.
• People were involved in the planning of their care. One person told us, "I am involved in my care. Staff give me the opportunity to say what I want, and they respect my decision."
• A range of platforms were also in place to enable people to express their views. These included, regular meetings with their keyworkers, service user guide, which provided information to people, tailored communication and regular surveys.

Respecting and promoting people's privacy, dignity and independence
• People told us that staff respected their privacy and dignity. They told us staff knocked on doors and asked for permission before entering their rooms. We observed a member of staff knocking on people's doors to ask if people could speak with us.
• We observed people moved around freely as they wished. One person was going to and from the dayroom in a wheelchair without assistance.
• Staff told us they promoted people's independence by supporting them to manage as many aspects of their care as they could. During lunch, several people ate their meals at their own pace without being rushed.
• Privacy was upheld in the way information was handled. The service recognised people's rights to privacy and confidentiality. Confidentiality policies had been updated to comply with the General Data Protection Regulation (GDPR) law. People's care records were stored securely in locked cabinets in the office and, electronically, which meant people could be assured that their personal information remained confidential.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People received person centred care. We observed a range of practices that reflected this. For example, people's values and preferences were respected, families were involved in people's care as appropriate and people had access to appropriate care and information.

• People's choices were respected. They chose their meals, activities, and what they preferred to wear. Equally, their gender preference for personal care was respected. One person told us, "I am happy with either gender but for personal care I prefer a female staff, and this is always respected."

• People's support plans were regularly reviewed by staff. This helped to monitor whether support plans were up to date and reflected their current needs. This ensured any necessary changes could be identified and acted on at an early stage.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The service identified and recorded people's information and communication needs. Information was presented in different formats to enable people to communicate to the best of their abilities. For example, staff used pictures, gestures, video, audio and big print to make information accessible to people. The lift had braille and voice announcement to assist people who were visually impaired.

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

• People were supported to maintain personal relationships with family and friends. Their care plans detailed their preferences relating to social activities. People's relatives and friends were invited to special events such as birthdays, Christmas parties and BBQs. One person told us, "People who are important to me are welcome and can visit me any time." Another person said, "I don't feel lonely living here. If I was at my flat I would be very lonely."

• People were supported to take part in activities. One person told us, "I am involved in a lot of activities. Someone comes to support me with cooking. Another person said, "I do most activities with this particular person. We go out and do lots of things together."

• There was a programme of activities organised by the home in partnership with people. People participated in a range of activities, including quizzes, puzzles and cooking. In one example the activity co-

ordinator involved a group of people in a baking session. One person read the list of ingredients and others took turns to weigh each ingredient.

Improving care quality in response to complaints or concerns
• The service had a range of approaches to gather people's views and experiences. One of these was a complaints procedure, which people and their relatives were aware of. The procedure explained the process for reporting a complaint.
• People and their relatives felt they would be listened to if they needed to complain or raise concerns. They told us they could discuss any concerns they had with the registered manager and were confident any issues raised would be dealt with.
• Five complaints had been raised in the last 12 months, which had been investigated and concluded satisfactorily.

End of life care and support
• At the time of the inspection no one was receiving end of life care. Some people's choices and preferences regarding their end of life care had been explored with them and documented. However, some people were not willing to discuss end of life care. The service should find creative ways of engaging people in discussions about end of life care, including involving advocacy organisations. This is important because a sudden death may occur.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Continuous learning and improving care
At our last inspection in January 2019 we found the service was not well-led and we rated the provider as 'Requires Improvement' in this key question. This is because further improvements were required. The provider's systems and processes did not enable improvement. At this inspection we found that progress had been made. However, further improvements were required in their incident reporting systems so that learning points could be actioned to reduce the chance of similar incidents reoccurring.
• There was a quality assurance process, which allowed the service to monitor its performance against standards to be achieved. Information to measure quality was collected in several ways, including audits, complaints, CQC reports, local authority monitoring reports, accidents and incidents and surveys. This information was then used to decide areas to make improvements.
• Improvements had been made in response to our inspection report of January 2019. Our report highlighted a range of failings including, the way medicines were managed and administered, staff recruitment and governance systems. At this inspection we found improvements had been made.
• However, we were concerned with how the service was dealing with incidents of medicines errors. Investigations focussed on the individual staff member as opposed to other root causes, including organisational systems.
• We discussed the concept of 'root cause analysis' (RCA) and other whole systems approaches to investigating medicines errors with the registered manager. RCA is the structured way of investigating medicines errors to determine the underlying causes. The registered manager told us she would review incident reporting systems.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People received person centred care. They had regular meetings with their key support workers. This enabled staff to keep up to date with people's changing needs, so they could continue meeting people's needs. We discussed with the registered manager the need to develop more creative ways for people having more control over their own medicines and money. Where possible, storing medicines or keeping people's money securely in their own rooms is consistent with values of person-centred care.

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 registered manager complied with the duty of candour. This is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We had been notified of notifiable events.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There were clear management structures in place. Staff were clear about their own roles and those of the managers. They were aware of their responsibilities and the reporting structures in place. All staff we spoke with told us the registered manager was 'approachable and supportive.
• We found the registered manager was committed to improving the service. She was knowledgeable about issues and priorities relating to the quality and future of the service. For example, she told us staff recruitment was a priority. The service was actively recruiting for the right staff, who had the right values and skills to support and drive improvement. People using the service were involved in this.
• People described the registered manager and the service in complimentary terms. They told us, "The manager always comes around to see if we are alright." Another person told us, "She is very responsive to feedback and they act on it as well."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There was an open culture within the service. The service used a range of ways to receive feedback from people, people's relatives and staff. Surveys were carried out annually. People had regular one to one meetings with their keyworkers. Staff told us team meetings provided an opportunity to raise issues and felt confident and supported in doing so.
• The registered manager was knowledgeable about the characteristics that are protected by the Equality Act 2010, including age, disability, gender reassignment, race, religion or belief and sex. We found these had been fully considered in relevant cases.

Working in partnership with others
• The service worked together and with other health and social care professionals to understand and meet people's needs. We could see evidence of this in records, including appointments with relevant professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some staff responsible for the management and administration of medication were not suitably trained and competent.

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 systems assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity