

Mrs M Lane

Kingsley House Residential Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We undertook an unannounced inspection of Kingsley House on 31 January 2018. The service was last inspected on 13 January 2016, when we rated the service Good overall.

Kingsley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Kingsley House provides accommodation and personal care for up to three older people, some of whom were living with the experience of dementia. There were three people living at the service at the time of our inspection, although one person was in hospital.

The provider is not required to have a registered manager in place because they are registered as an individual. The provider runs and manages the service.

Not all the risks to people's wellbeing and safety had been assessed, and where risks had been identified, the provider had not always taken appropriate action to mitigate these.

The environment was not designed in a way to support people who were living with the experience of dementia.

There were few organised activities and these were not always person-centred and did not always meet the needs of people living with dementia.

Staff received training, although the training matrix had not been updated and training certificates were not always available. The provider was able to provide evidence of training after the inspection.

The provider did not always ensure that lessons were learned when things went wrong. Incident and accident forms did not include an analysis or actions needed to minimise the risk of reoccurrence.

Although staff supported people in a kind and caring way, they rarely interacted with people apart from asking them what they wanted to eat or drink.

People were not always supported with their individual needs in a way that valued their diversity, values and human rights.

The provider had a number of systems to monitor the quality of the service and put action plans in place where concerns were identified. However, audits had failed to identify the issues we found.

There were systems in place to protect people from the risk of infection and the environment was clean and

free of hazards.

People's needs were assessed prior to receiving a service and care plans were developed from the assessments. Care plans were comprehensive and contained details of people's background and care needs.

There were procedures for safeguarding adults and staff were aware of these. Staff knew how to respond to any medical emergencies or significant changes in a person's wellbeing.

Staff followed the procedure for recording and the safe administration of medicines.

The service employed enough staff to meet people's needs safely and had contingency plans in place in the event of staff absence. Recruitment checks were in place to obtain information about new staff and ensure they were suitable before they started working for the service.

The provider was aware of their responsibilities in line with the requirements of the Mental Capacity Act 2005 (MCA) and staff had received training on this. People's capacity to make decisions about their care and treatment had been assessed. Processes had been followed to ensure that, when necessary, people were deprived of their liberty lawfully. However, we did observe an incident where a practice was being used to restrict the liberty of a person without proper processes being in place to help safeguard the right of the person.

People's health and nutritional needs had been assessed, recorded and were being monitored. People had access to healthcare professionals as they needed, and their visits were recorded in people's care plans. People's end of life wishes were recorded and respected.

Staff received supervision and appraisals. The provider sought guidance and support from other healthcare professionals and attended workshops and provider forums in order to keep abreast of developments within the social care sector and shared important information with staff.

There was a complaints procedure in place which the provider followed. However no complaints had been received in the last year.

Staff told us that the provider was approachable and supportive and encouraged an open and transparent culture within the service. They said that people and staff were supported to raise concerns and make suggestions about where improvements could be made.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to Safe Care and Treatment, Dignity and respect, Safeguarding service users from abuse and improper treatment, Person-Centred care and Good Governance. You can see what actions we told the provider to take at the back of the full version of this report. We also made a recommendation in relation to the environment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Not all the risks to people's wellbeing and safety had been assessed, and where risks had been identified, the manager had not always taken appropriate action to mitigate these.

Incident and accident forms did not include an analysis or actions needed to minimise the risk of reoccurrence.

Staff followed the procedure for the recording and safe administration of medicines.

There were procedures for safeguarding adults and staff were aware of these.

There were enough staff on duty to meet people's needs in a timely manner. Checks were carried out during the recruitment process to ensure only suitable staff were being employed.

Requires Improvement ●

Is the service effective?

The service was not always effective.

The provider was aware of their responsibilities in line with the requirements of the Mental Capacity Act 2005 and understood its principles. However, we did observe an incident where a practice was being used to restrict the liberty of a person without proper processes being in place to help safeguard the right of the person.

The environment was not designed in a way to support people who were living with the experience of dementia.

Staff received training, although the training matrix had not been updated and training certificates were not always available. The provider was able to provide evidence of training after the inspection.

People were supported by staff who were supervised and appraised.

Requires Improvement ●

People's health and nutritional needs had been assessed, recorded and were being monitored. People were protected from the risks of inadequate nutrition and hydration.

Is the service caring?

The service was not always caring.

Although staff supported people in a kind and caring way, they rarely interacted with people apart from asking them what they wanted to eat or drink.

People were not always supported with their individual needs in a way that valued their diversity, values and human rights.

Care plans contained people's background and their likes and dislikes.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

There were few organised activities and these were not always person-centred and did not always meet the needs of people living with dementia.

People were consulted about their end of life wishes and these were recorded in their advanced care plans.

People's individual needs had been assessed and recorded in their care plans prior to receiving a service, and were regularly reviewed. Care plans contained enough detail for staff to know how to meet peoples' needs and were written in a person centred way.

There was a complaints policy and procedures in place.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

The provider had a number of systems in place to monitor the quality of the service and put action plans in place where concerns were identified. However, audits carried out by the provider had failed to identify the issues we found.

The service conducted satisfaction surveys for people and visitors. These provided information about the quality of the service provided.

Requires Improvement ●

Staff found the provider to be approachable and supportive.

The provider encouraged good communication with staff and people who used the service, which promoted a culture of openness and trust within the service.

Kingsley House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 31 January 2018 and was unannounced.

The inspection was carried out by one inspector. 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 reviewed the information we held about the service, including notifications we had received from the provider informing us of significant events that occurred at the service. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

As part of the inspection, we spent time observing how staff provided care and support for people to help us better understand their experiences of care. This was because the people who lived at the home had complex needs and were unable to tell us about their experience of living there. In order to do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not speak with us.

During the inspection we looked at the care records of all three people who used the service, three staff files and a range of records relating to the management of the service. We spoke with the provider, the administrator and a care assistant. Following the inspection, we contacted four healthcare professionals but were only able to obtain feedback from one.

Is the service safe?

Our findings

Not all risks that people faced had been identified and assessed and we identified some concerns which could potentially cause harm to people. For example, the two people whose bedrooms were situated on the first floor were living with dementia which meant that their condition often led them to be disorientated to time and place. We saw that from their bedrooms, there was a small landing which led straight to an unprotected set of stairs. We discussed this with the provider as there was a risk that someone could fall down the stairs. This risk had not been assessed. They told us that people were always supervised, including at night, because there was a waking member of staff on duty. However, they started to assess the risk and take action during our inspection.

We saw in a person's care record that a healthcare professional had stated in August 2017 that the person's mobility had decreased and that it would be advisable for a more suitable placement to be found. We asked the provider what action they had taken following this to enable this to happen. We were told that a social worker had reviewed the person with a view of moving them to a more suitable environment. However there was no record of this review. We asked how the person was able to go up and down the stairs, taking into account their reduced mobility and the use of a walking aid. The provider told us the person was able to do this with staff supervision. We witnessed the person going up and down the stairs and saw they were able to do this by holding on to the handrails, however when coming down the stairs, the staff member had to move past the person to get in front of them. This posed an additional risk to both the person and the member of staff in the event the person would lose their balance or trip. The provider had not carried out an assessment of the risks posed by the person using the stairs.

Furthermore, the provider had not taken any action to refer the person to the GP or to involve relevant professionals such as occupational therapists (OT). The administrator sent a fax to the GP on the day of our inspection to request an OT assessment.

Accidents and incidents were recorded in an accident book and in people's care records. However, these did not include details of any investigation or action taken to prevent reoccurrence. None of the records indicated a review by the provider and there was no indication of lessons learned.

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

Other risks to people's safety and wellbeing had been assessed and there were action plans in place to mitigate these risks.

Staff had received training in infection control and we saw they used protective equipment such as aprons and gloves when carrying out personal care. All areas of the home were clean and tidy and free of any hazards and all cleaning products were safely locked away. Overall the rooms were satisfactory and people had personalised their own rooms with photographs and objects of their choice.

Staff undertook regular checks during the day and night to ensure that people were safe. People were protected through the provider's safeguarding procedures. The provider knew how to raise alerts of incidents of potential abuse to the local authority's safeguarding team as necessary. They also notified the Care Quality Commission (CQC) as required of any notifiable incidents. However there had not been any safeguarding concerns recently. Staff had access to the safeguarding policy and procedures and were aware of the whistleblowing policy.

The provider had a health and safety policy in place, and staff were aware of this. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. A general risk assessment was in place which included medicines administration, infection control and manual handling. Equipment was regularly serviced to ensure it was safe, and we saw evidence of recent checks. This included fire safety equipment such as fire extinguishers.

The service had taken steps to protect people in the event of a fire. People had Personal Emergency Evacuation Plans (PEEPS) in place. These took into account people's individual needs and abilities and provided instruction about how to support them to evacuate the building safely in the event of a fire. Windows had recently been replaced and were all fitted with window restrictors to prevent them from opening wide and these were regularly checked.

There were only two people at the service at the time of our inspection so the provider deployed one staff member on duty all day and one waking staff all night to keep people safe and meet their needs. A staff member told us, "It's fine, and [provider] comes in every single day. She helps and supports us whenever we need it."

We checked medicines storage and medicines administration records (MAR) charts for all three people who used the service. All prescribed medicines were available and were stored in a locked medicines cupboard. A temperature chart was in place and temperatures recorded were within targets. MAR charts were completed appropriately and there was no gap in staff signatures. We checked the amount of tablets in each pack and found that the stock corresponded to the staff signatures. This provided us with some indication that people were receiving their medicines as prescribed.

Staff undertook medicines training and the provider carried out regular competency checks. The provider undertook regular medicines audits and we saw that these were thorough. No errors had been identified in the last three months we checked.

Recruitment practices ensured staff were suitable to support people. We looked at four staff files. There were records of checks to ensure staff had the relevant previous experience and qualifications. Checks were carried out before staff started working for the service. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check was completed.

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the inspection we observed staff using a practice to prevent people from walking around the home, which could be restrictive. They placed a table in front of people to prevent them from getting up from their chair. There was no evidence that consent has been sought from them or that best interests decisions had been made in regards to the restrictive practice. We observed one person repeatedly moving the table to one side. However staff kept putting it back in front of them. We discussed this with a staff member during the inspection who had not identified this as a restrictive practice and fed this back to the provider at the end of our inspection.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had identified people who might have been deprived of their liberty and had taken appropriate action to make sure these were in people's best interests and were authorised by the local authority as the Supervisory Body.

Staff employed at the service told us they had received training in the MCA and we saw that MCA training was provided to staff.

People were consulted in other aspects of their care and we saw evidence that they, or their representatives, had signed consent forms. During the inspection, we saw examples where people were consulted and consent to their care and treatment was obtained verbally.

The provider had made some improvements to the environment to suit the needs of people living with dementia. For example, they had painted the toilet door red and had displayed photographs of people on their bedroom doors. However, the colour schemes, lighting and additional features did not reflect good practice guidance for environments for people who were living with the experience of dementia. There was insufficient signage to help people find their way to different areas of the home. The National Institute of

Care Excellence (NICE) guidance: 'Dementia: Supporting people with dementia and their carers in health and social care' states, "Good practice regarding the design of environments for people with dementia includes incorporating features that support special orientation and minimise confusion, frustration and anxiety." The guidance also refers to the use of "tactile way finding cues." The Department of Health guidance on creating "Dementia friendly health and social care environments" recommends providers "enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do".

We recommend that the provider seek relevant guidance in relation to improving the environment to meet the needs of people living with the experience of dementia.

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and people and/or their representatives had been involved in discussions about the care, support and any risks that were involved in managing the person's needs. People had been referred by the local authority and the provider had obtained all relevant information from them including people's background and their medical history. Staff told us this information helped them deliver a personalised service to each person who used the service.

People were supported by staff who had appropriate skills and experience. Staff told us they had received an induction when they started to work for the service. This included training and working alongside other staff members. Staff told us they were able to access the training they needed to care for people using the service and this included online and classroom based training. One staff member said, "We get regular training. I did NVQ level two and three. Quite an achievement. I think I am trained well."

We viewed the training matrix where the provider recorded all training delivered to staff. This indicated that staff had received regular training in subjects the provider identified as mandatory, such as moving and handling, health and safety, safeguarding, first aid, food hygiene and infection control. They also received training specific to the needs of people who used the service such as dementia, nutrition and hydration and end of life care. However we noticed that two staff members had not received refresher training in a range of subjects. We discussed this with the provider who told us that the staff members had received the training but the matrix had not been updated. There was no evidence of certificates in the staff members' records to certify this. Following the inspection, the provider sent us two training certificates for one member of staff and told us they were trying to obtain the others.

People were cared for by staff who were well supported. During the inspection we spoke with members of staff and looked at staff files to assess how they were supported within their roles. Staff told us they received regular supervision meetings with the provider. One staff member said, "I am well supported. More or less every day we get supervision as [provider] is here every day." The provider told us that these meetings provided an opportunity to address any issues and to feedback on good practice and areas requiring improvement. Staff also received a yearly appraisal. This enabled staff and the provider to reflect on their performance and to identify any training needs or career aspirations.

People's nutritional needs were recorded in their care plan. We viewed the menus for the week and saw that these changed daily on a six weekly cycle. The food served was hot, nutritious and looked appealing. The meal on the day of our inspection was cooked using fresh ingredients. We noticed that people enjoyed their meal and finished it, before being offered more. People had adequate amounts to drink throughout the day.

There was information about people's dietary needs, including any allergies in their care plans. People's

likes and dislikes were recorded and respected. For example, one person liked rice and meals that reminded them of their country of origin and staff told us they offered this regularly.

People were given the support they needed to stay healthy. The provider was responsive to people's health needs. Staff told us that external health care professionals provided guidance for them on how to support people with various conditions and visited people regularly. Records of external professionals' visits were recorded and included the reason for the visit and actions taken.

Is the service caring?

Our findings

We saw that people were supported by staff in a kind and caring way. However, we saw that one person had a runny nose whilst drinking their tea. Although staff came in and out of the room, they did not notice until we alerted them to this, so they could provide a tissue for the person to use. The television was kept on all day, first with a morning programme on and later, the classical music channel. Nobody consulted people about what they wanted to watch or listen to.

The menu for the day was displayed on a board in the lounge, however it was written in small prints and people could not read this from their armchairs. In addition, staff had not taken into consideration one person who had a vision impairment. We did not see staff interact with this person to provide information in a way the person could understand such as by the use of a pictorial visual aid to facilitate communication about the food on offer. We discussed this with the provider who spoke with a member of staff. The menu was re-written in larger letters.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff and provider spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. Staff we spoke with knew people well and were able to tell us their likes and dislikes. People looked clean and well kempt and had clean fingernails.

The provider told us they ensured they listened to people's wishes and respected their choices. They commented, "I consult people if they are able to in the running of the home and what they want. Like food and activities." People were unable to tell us if they were involved and did not have relatives, so we were unable to verify this.

Staff were seen to knock on closed doors before entering and said they always respected privacy and dignity by ensuring that people's choices were respected and closing doors when delivering personal care. One person went and spent time in their room in the afternoon to listen to music. Staff told us they enjoyed doing this and this was respected.

Is the service responsive?

Our findings

There was a folder which contained a plan of scheduled activities such as exercises to music, drama therapy, ball games and newspaper. However, there was no activity board displayed so people were not aware what activities were planned each day. On the day of our inspection, 'ball games' was scheduled, however this activity did not take place.

Apart from when people needed support to go to the toilet, or when they were asked if they wanted food or drink, staff did not spend time with people, and did not interact with them. We spent the day of the inspection observing people and staff in the lounge and witnessed staff, including the provider, redirecting a person to their chair each time they got up to walk around. None of the staff tried to understand why the person was restless or suggested to walk with them.

People spent all day including mealtime, in the lounge with the television on. People were not asked what they wanted to watch. During the day, we observed one person looking at a newspaper for some of the time.

At one point a member of staff entered the lounge with a ball that was split into sections, where each section displayed a question to trigger memory and facilitate conversation. The staff member interrupted the person reading a newspaper and started asking, "What was your favourite toy as a child." The person indicated they wanted to read the newspaper, but the staff member said, "Ok but let's do this first" and repeated the question loudly. When the person looked disorientated and showed no interest, they went straight to the other person and showed them one of the questions, although they knew the person was visually impaired. Again when the person showed no interest, they put the ball away and left the room, offering no alternative activity.

One person's activity plan stated they like to read and watch television. However the provider had told us that this person did not watch television or read now due to their eyesight deterioration. We also witnessed the provider giving the same person a newspaper, to which they said, "I can't read without my glasses." We discussed this with the provider who told us the person did not wish to wear their glasses. However, we did not see staff bringing them their glasses and encouraging them to wear these.

One of the people using the service was observed singing or reciting the alphabet repeatedly throughout the day. Staff told us the person liked music and singing. However, they failed to validate this interest or engage in a conversation about this.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were developed from the initial assessments and contained information about the care needs of each person and how to meet these. Care plans were detailed and included the person's needs and wishes in all areas of support including personal care, diet and weight, sight, hearing and communication, oral

health, mobility, cognition, personal safety and social contacts.

Each section highlighted the level of support people required and what they were able to do by themselves. For example, where a person was experiencing difficulties sleeping, their care plan stated, "Give a warm milky drink before bedtime, ensure person has sufficient pillows and appropriate bedclothes for current weather conditions" and where another person was at nutritional risk, their care plan stated that the person needed "Encouragement to eat to ensure they receive enough food." Care plans were reviewed monthly and reviews were signed by people or their representatives.

The service had a complaints procedure in place and this was displayed in communal areas. The provider told us they had not received any complaints in the last year. They added that they aimed to listen to people and when there was an issue or a query, this was addressed immediately.

The provider had an 'end of life policy'. People's end of life wishes were recorded in their care plans and each person had an advanced care plan in place. This included where they would like to be cared for at the end of their life. It identified each person's medical conditions and needs and detailed how these needs would be met. For example, if a person's wish was to die at the home, the risks and benefits were recorded. The end of life care plans were written clearly and in a person-centred way. The provider managed another service which had achieved accreditation to the Gold Standard Framework (GSF), an approach to planning and preparing for end of life care. They told us they used this approach in Kingsley House.

Is the service well-led?

Our findings

The provider had put in place a number of different types of audits to review the quality of the care provided. These included medicines audits, environmental checks and health and safety checks. In addition, they came into the home daily to speak with staff and people who used the service and carry out observations of the care and support people received.

However these audits had not always been effective and had failed to identify the issues we found in relation to risks management, the provision of activities to meet the individual needs of people, the quality of the environment and meeting the needs of people living with dementia. The provider had also not identified that using a table to prevent a person from getting up and walking could be seen as a restriction and there was no best interests decision in this regard.

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

The provider told us people were supported to feedback about the service through meetings and quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether their needs were being met. It also included questions about the quality of the food, the environment and their social needs. However they told us records of meetings and quality questionnaires were kept at their other service, so we were unable to view any of these.

The provider divided their time between the service and their other service but told us they visited daily to discuss any issues with the staff on duty. They also said they were available to speak with people who used the service and staff at anytime. They added, "I come in every single day. I check everything and always talk to staff and people."

Staff were positive about their job. They told us they felt supported by the provider and were confident that they could raise concerns or queries at any time. Their comments included, "I have not had any concerns. If we need anything, [Provider] listens and supports me. The manager is approachable, not a procrastinating person. We ask something, she gets it done. We can sit down and have a chat. It's exceptional in my view."

Staff told us they had regular meetings. We were unable to view these as the provider told us they were kept at their other service. Following the inspection, they sent us the minutes of three meetings that took place recently. We saw that these were well attended. The items discussed included health and safety, training and issues concerning people who used the service.

The provider kept abreast of developments in social care by attending the provider forums organised by the local authority. They also attended training and networking meetings which included lectures about different topics. They told us that all important information was cascaded to the staff team to ensure they were informed and they thrived to continue to improve their practices.

There was a business plan in place which included what was planned in terms of refurbishment and areas of improvement. We saw that some improvements had been made, such as new windows, new flooring, painting and decorating and installing CCTV cameras in communal areas and outside. However, as stated previously there was scope for the environment to be more suitable for people living with dementia.

The service worked closely with healthcare and social care professionals who provided support, training and advice so staff could support people safely at the service. Records showed that professionals visited people at the home and had established good working relationships with staff.

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 The registered person did not do everything reasonably practicable to make sure that people who used the service received person centred care and treatment that was appropriate, met their needs and reflected their personal preferences. Regulation 9 (1) (a) (b) (c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity and respect. Regulation 10 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always assess the risks to the health and safety of service users of receiving the care or treatment Regulation 12 (1) (2) (a) (b)
Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care

Safeguarding service users from abuse and improper treatment

The registered person had not safeguarded people from abuse or improper treatment

Regulation 13 (7) (b)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The registered person did not assess, monitor and improve the quality of the service.

Regulation 17(1) (2 (a) (b)