Mrs M Lane

Blakesley House Nursing 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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Blakesley House Nursing Home on 13 August 2015, the inspection was unannounced. There had been a previous inspection of this service on 25 July 2014 where the Regulations we inspected were met.

Blakesley House Nursing Home is registered to provide accommodation and personal care as well as nursing care for up to 22 older people. At the time of the inspection, 13 people were living at the home. The provider is not required to have a registered manager in place and the provider runs and manages the service.

Summary of findings

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. The provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for at least one person for whom bedrails were being used.

We found evidence that staff did not always understand the need to obtain consent from people. For example we found photographs of bruising to a person's body part for which consent had not been sought.

Risk assessments gave little or no information on how risk was managed. Although people had individual fire risk assessments in their care plans, they did not have any Personal Emergency Evacuation Plans (PEEPS). We found that the information in the fire risk assessment did not always reflect the information in the care plans. For example, a person's risk assessment stated that they would need the assistance of one carer to evacuate in the event of a fire, but the care plan said that they needed the assistance of two carers to mobilise.

Not all the recruitment records we checked were thorough and complete, although the provider had ensured that staff had a Disclosure and Barring Service (DBS) check prior to starting work.

Training records were inconsistent, and the provider was unable to locate the record for all staff training. The staff did not have regular individual supervision meetings with the provider. The staff did not receive an appraisal.

We found two cleaning products (which could have been hazardous) in an unlocked cupboard on the first floor and made the provider aware of it. They did not lock the cupboard or remove the products.

Although the provider told us that they had regular staff meetings, they were unable to locate the minutes. However, the staff told us that communication was good and they had regular handover meetings but these were not recorded. The staff said that they felt supported and that the provider was always around.

Care plans were in place, and people had their needs assessed. The care plans contained a lot of information but did not always reflect the needs and wishes of the individual. There were regular reviews of the assessments and care plans for some people but not for others. Important information was not always followed up and recorded. For example, we saw information about a bruise sustained by a person living at the home. This was correctly recorded on the day it was noticed, but there was no follow up in the daily notes.

There were no organised activities on the day of the inspection and we observed people sitting in the lounge with nothing to do apart from listening to music in the morning and watching TV in the afternoon. Although most of the people were living with dementia, we did not see any evidence of a dementia friendly environment or activities.

The building appeared clean and checks on infection control and health and safety were recorded.

There was a procedure for recording, storing and administering medication and that the staff were aware of this and received regular training in administration of medicines.

People gave positive feedback about the food and we observed people being offered choice at the point of service. People had nutritional assessments in place. People had access to health care professionals as they needed, and the visits were recorded in their care plans.

People had good relationships with staff. The staff were kind, attentive and had a gentle manner. The relatives we spoke with praised the staff's kindness and the care their relatives received.

We found a number of breaches of the Health and Social Care 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Risk assessments were in place but gave little or no information on how risk would be managed.

Recruitment procedures were not always carried out thoroughly.

Medicines were managed safely. Effective systems were in place to ensure safe administration and staff had received training in administration of medicines.

Staff understood the principle of safeguarding. They had a good understanding of the types of abuse and how to prevent them.

Requires improvement

Is the service effective?

The service was not always effective. Where people lacked the capacity to make decisions, the staff had not followed the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff did not receive regular supervision and appraisal and some staff training was inconsistently provided.

People had access to a GP, dentist and other community health services. People had regular home visits by the GP.

People were protected from the risks of inadequate nutrition and dehydration. People had a choice of food for every meal and if people did not want what was on offer they would be offered an alternative.

Requires improvement

Is the service caring?

The service was caring. Staff interacted with people in a friendly and caring way. Relatives and professionals said that the people using the service were well cared for.

Care plans contained people's personal history, likes and dislikes. People were supported by caring staff who respected their dignity.

Where people were able to make choices, they told us that staff respected this.

Good

Is the service responsive?

The service was not always responsive. Records which detailed people's health and care support were not always maintained or accurate, and were not always updated.

People and their relatives were not regularly consulted about their views and asked for their input concerning the home.

There was a lack of activities on offer. There was no evidence of dementia-friendly activities or person-centred activities taking place.

Requires improvement

Summary of findings

Is the service well-led?

The service was not always well-led. The provider could not locate some of the records we requested. Some records were not filed appropriately, including some supervision records which were in a box with other paperwork.

We received positive feedback about the provider from staff, relatives and professionals and people had confidence in their ability to run the home.

Although the provider told us that they held meetings with people and relatives, we did not see any records of them. The provider was unable to locate any of the minutes at the time of the inspection.

Requires improvement

Blakesley House Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 August 2015 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed the information we held on the service including previous reports, notifications of significant events, accidents and safeguarding alerts. During the inspection we observed care practice and tracked the care provided through looking at records and care plans for four people.

On the day of the inspection, we spoke with provider, a nurse, a cook/carer, two care staff and eight people who used the service. Not everyone was able to tell us about their experiences so we observed how people were being cared for. We looked at records which included the care records of four people living at the home, the recruitment records for four members of staff, the provider's records of staff supervision meetings, evidence of staff training and the provider's records of checks on the environment. We checked how medicines were managed and administered by looking at relevant records and speaking to the nurse in charge. After the inspection visit, we spoke with three relatives of people who used the service, the GP, a pharmacist and a hairdresser.

Requires improvement

Is the service safe?

Our findings

The provider had created risk assessments for people in relation to fire, medicines, bed-rails and skin integrity. However, these consisted of a number of tick boxes and there was limited additional information. The assessments gave little or no information on how the risk would be managed, including for one person who was known to smoke in their bedroom. They had been told that this practice was not permitted at the home but they continued to do so. The provider told us the staff were aware of this but it was not recorded anywhere. Risk assessments stated that signs were in place and the person was told they were not permitted to smoke, but did not have a risk management plan which reflected the reality that they were smoking the in their room.

We saw that each file we checked had a personal risk assessment in place. However there were no Personal Emergency Evacuation Plans (PEEPS). One risk assessment stated that in the event of a fire, one carer was needed to assist evacuation. However the person's care plan stated that they needed two carers to assist with mobilising. Another person's risk assessment stated that they were at high risk due to a physical condition and would panic in the event of a fire. However, there was no action plan in place to support them if they did panic. Several people's care plans stated that they needed the assistance of two carers. The home did not have a clear action plan in the event of a fire. There was no evidence of moving and handling risk assessments in the files that we checked.

We saw that an unlocked cupboard contained two cleaning products. These were potentially hazardous and required safe storage under the Control of Substances Hazardous to Health COSHH Regulations. We told the provider about this issue, however they did not lock the cupboard or remove the products.

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

There was evidence that the staff had taken part in some evacuation exercises as well as a tour of the building with the provider to identify fire detectors. The staff had watched a fire safety DVD. We saw that a fire risk assessment for the home was in place and was regularly updated by the provider. There was a premises inspection report on file from London Fire Brigade.

The provider's recruitment procedures included making checks on the suitability of staff to work with vulnerable people. The provider interviewed staff, although not all the recruitment records we viewed included evidence of these interviews. There was evidence that staff had completed application forms, given a full employment history, health history and photograph. The provider had ensured staff had a Disclosure and Barring Service (DBS) check prior to starting work. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. There was evidence that reference checks were not always carried out for new staff. The provider had not requested any references for one member of staff who had been employed in 2014 and the only reference held was "to whom it may concern" and not specifically about the person's role at the service. It had not been written by either person named as a referee on the staff member's application form. Another staff member had a reference written by someone who knew their partner and did not know them personally. They did not have any references from previous employers. The provider was not able to guarantee the suitability of these staff before they were employed because they had not received appropriate references.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us "staff are always available when I need them", "I have my call bell here and I can call them whenever I need, they come straight away", "I buzz and they come."

The provider informed us that there were two carers and one nurse from 8am-10am then from 10am-1pm, one carer and one nurse were on duty each day. There were two carers and one nurse from 2pm-8pm, and one carer and one nurse at night from 8pm-8am. The cook and the cleaner were also employed as carers and often work in this role. On the day of the inspection, the cook was working as a care worker. The provider was supernumerary. Staff told us that there were enough staff on duty as they only had 13 people living at the service at the time of the inspection.

Requires improvement

Is the service safe?

We spoke to a regular visiting professional who said that the home was always clean and fresh and people were "happy and safe." They told us "I have been coming here for a long time and the people speak to me. Nobody has ever told me anything of concern. Nobody ever looks upset or worried."

The building appeared clean and checks on infection control and health and safety took place. The staff carried out checks on food temperatures, furniture and fittings, water temperatures, fire equipment, mattresses and cleanliness on a daily basis. We saw that the emergency lighting and the safety lighting system were recorded as checked weekly by the provider. Other safety inspections such as for the lift, legionella, electrical, gas and fire extinguishers had taken place recently and were recorded appropriately. However some of the plugs sockets had an out of date sticker on them.

Medicines were stored safely and records were kept for the medicines received and disposed of. There was specific storage for controlled drugs. The fridges used for specific medicines had their temperatures checked daily and the records indicated that they were at the appropriate temperature. Each boxed medicine was clearly labelled with the person's name and start date. The Medicine Administration Records (MAR) charts were clear and had a photograph of the person, and details of their medication, instructions and times of administration. We checked the MAR charts for all the people living at the home and saw that staff signed accurately, and when medicines were refused or omitted, a reason was recorded at the back of the chart. Medicines which were not taken were sent back to the pharmacist and recorded accurately in the returns book. The pharmacist told us that they had been working with the home for six years and had a good relationship with the provider and staff. They came unannounced twice a year to the home to carry out a thorough audit of medicines and they told us that there was never any concern. They told us "everything is done in order", "the home works really well with the pharmacy and the GP practice to deliver good care." The pharmacist told us that they delivered training to staff in-house twice a year.

The provider told us that they had procedures for safeguarding vulnerable adults and worked well with the local authority. There was evidence that relevant incidents were reported to the local authority and the Care Quality Commission (CQC) had received notifications of these. The staff we spoke with showed an understanding of safeguarding and knew who to contact with any concerns they may have. A staff member we spoke to said that they had received training in safeguarding, although we could not see training record to evidence this. A visiting professional told us that they would feel comfortable reporting any concerns to the provider as they felt that their concerns would be taken seriously and addressed.

Requires improvement

Is the service effective?

Our findings

The provider told us they had followed the requirements of the Mental Capacity Act (MCA) and had made an application for a Deprivation of Liberty Safeguards (DoLS) for one person who had expressed a wish to leave the house alone. They were unable to find the documents relating to this. There was no evidence of a best interest meeting. The provider told us that there had been no response or authorisation from the local authority. They said that they had not followed this up at the time of our inspection. There were no other DoLS application made although other people in the home had been assessed as lacking capacity to make specific decisions. Bedrails were used on one person's bed. These restricted the person from getting out of bed on their own. The person had not consented to their use.

The provider told us they did not feel practices at the home were restrictive. However, we observed that during our inspection when one person stood to leave their chair during the morning they were told to sit down by a member of staff. Another person attempted to leave their chair in the afternoon, they were guided back to their seat by a member of staff. Although this was done in a gentle manner, the staff were in effect restricting people's movement. The staff we spoke with did not demonstrate an understanding of this and could not explain what restrictions were being used. This meant that people were being unlawfully deprived of their liberty.

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

Care plans contained an assessment entitled "mental capacity assessment". The four records we looked at all said that the person "lacked capacity to make a particular decision". The other information was completed by answering set questions in a tick box. There was no information about what decisions the person was capable of making. We met one person who had the capacity to make decisions about their daily routines, what they wore, ate and did with their time. The "mental capacity assessment" for this person said that they lacked capacity, and had no other information. They had signed the "statement of agreement" in their care plan but on their profile and another part of their care plan requiring a signature the staff had written "unable to sign." There was a document entitled "advanced care planning decision" which indicated certain aspects of the person's care had been discussed with them and their next of kin but neither they nor their family had signed this.

The care plan for another person recorded that the person lacked capacity. There was a note to say that the care plan had been discussed with the family but the next of kin had not signed this.

The provider told us that all but one person had a Do Not Attempt Resuscitation (DNAR) in place. In the records we checked, we saw that they were in place. But these had not been signed by the person or their family. We were also not made aware on any person whose relative had obtained Lasting Power of Attorney in care matters which would enable them to deal with their relative's care.

One person had bedrails. There was an assessment in place but this was just in a tick box format. It did not include reasons for the bedrails, alternatives, discussion with the person or their family or a best interest discussion.

The staff had not received training about the MCA or DoLS and did not have an understanding about their legal responsibilities.

Staff did not obtain consent to take and display photographs including where a person had sustained a bruise.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said that they felt supported by the provider, and communication was good. They said that they had handover meetings every day and discussed the people's needs. They said that teamwork was good and staff helped each other. The provider was always around. Staff did not receive appraisals and did not know what they were.

Staff we spoke to on the day of the inspection said that they had received a two day induction before starting work at the service. One staff member said that they had booked and paid for a two day mandatory training themselves. The provider told us that they used online training and sometimes had access to training via the local authority.

The provider could not locate an up to date training record of all staff training. They said that the most recent training

Requires improvement

Is the service effective?

was evidenced in staff files. We checked four files and found that in one carer's file, there was evidence of recent training in medicines management, safeguarding, record keeping, fire marshalling and introduction to the Care Act. However in the file of a staff member employed as a nurse in 2014, there was no evidence of any training. In the other two carers' files, there was no evidence of any training in 2015. One last received training in 2014 and the other in 2013.

We found an induction checklist in place for two members of staff but not for the most recently employed. There was no evidence of formal induction, Skills for Care or any reference to the Care Certificate.

There was no evidence of any supervision for 2015 for any staff. One member of staff said that the deputy manager carried out supervision every three months, but there was no evidence of any records. The files we checked showed that two members of staff had received only two supervisions in 2014 and the two others only received one supervision. They have not had any formal supervision since April 2014.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had sessions with the staff to discuss certain areas of training each month. The records showed discussions regarding documentation, bathing, health and safety, dementia, falls and nutrition. There was no evidence of content in the record. Records were signed by some but not all staff.

The staff we spoke with said that they felt supported as the provider was always there and available to talk to. There was no evidence of team meetings. The provider said that they took place but could not locate records. The provider later called us to say that she had found several records of team meetings. The staff we spoke with said that there was good teamwork and good communication within the team, and the management was supportive.

The care plans contained nutritional assessments, and evidence of health care appointments. We were told by the staff that people had access to healthcare professionals whenever they needed, and this was appropriately recorded in care plans. We spoke with a visiting professional who said that the home's organisation "could be chaotic at times" and this at times had "caused some problems." For example, we were told that new people were not always registered promptly with the GP surgery. This had caused problems with somebody who only had three days of medicines as there had been a delay with the GP providing a prescription. They told us that they had no concerns about the clinical care of the people who used the service.

People gave positive feedback about the food and we saw people being offered choice at the point of service. It was freshly prepared and people were given sufficient size portions. The cook told us that they prepared a six week menu, and people were always offered two choices for every meal. They also had access to fresh fruit and food when they wanted. People told us: "the food is nice", "very nice – yes, I like what I had", "the food is always good and they cut it up or give it to me how I need it."

The staff monitored people's weight, nutrition and fluid intake. We saw that people's weight was stable or increasing indicating they were receiving adequate nourishment.

Good

Is the service caring?

Our findings

People told us that they thought the service was caring. Some told us, “the staff are very nice”, “they are all lovely”, “everyone is always lovely and sweet to me”, “good carers they take care of me”, “they have let me bring my own things for the room to make it my home.” We observed the staff being kind, attentive and had a gentle manner. They attended to people’s needs discreetly. People looked well kempt, they were clean and had clean hair and nails. Records showed that people had regular baths/showers, and personal care was recorded in care plans.

One staff member said “we are all here for the residents, and all my colleagues are kind and caring”, “we ask what people want to wear and how they wish their care to be, and where they want to be.”

All the visiting professionals told us that the staff were kind and caring and they had never had a concern about the care people received at the home.

One of the relatives we spoke with said, “They are brilliant! They are lovely. The staff really care”, another said, “I am very happy with the care my relative receives.”

In places, there were a lot of posters to inform the staff about best practice. Some rooms had not been personalised and there were not a lot of ornaments, pictures or additional personal touches, however, some people had been assisted to make their rooms homely. There was an unused extra bed in one of the double rooms.

The home was accredited to the Gold Standard Framework (GSF), an approach to planning and preparing for end of life care. They were expecting a follow up visit from the GSF assessor to maintain their level of accreditation.

Requires improvement

Is the service responsive?

Our findings

We saw in people's records that they had their needs assessed and the assessments were updated monthly. Care plans were in place and updated monthly for three of the records we saw, however there were no monthly updates for the care plan of a person who had lived at the home for three months. The care plans contained a lot of information but the information focussed mainly on people's clinical and medical needs, and did not have a lot of information about people's likes and dislikes. For example, one person's dislike said: "does not like having their head under water." Staff had however obtained meaningful information about past life, hobbies and interests. We saw a photograph of a large bruise and basic information to describe this. The photograph was not dated and there was no care plan to describe how this had been identified, diagnosed or treated. There was no evidence that the person had seen a GP about this injury or what the treatment plan was. The staff had referred to care of the bruise in daily logs on some days, but this was not consistent The nurse on duty was able to describe how the bruise had happened, that the person had seen a doctor and it was healed. However, the records for this person did not give this information and there was no plan to show the progress of the bruise and treatment given.

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

One of the relatives we spoke with felt that the provider responded well when an incident involving their relative took place, they said "the staff were so worried." There were two activity notice boards, which did not have the same information. Neither of them reflected what was taking place on the day of the inspection. The board in the lounge said that activities on the day of the inspection were a sing-a-long and a Relatives Meeting. Neither of these activities took place. There were no organised activities for the duration of the inspection. Throughout the inspection, seven people were seated in the lounge. From 10.30am until 11.55am the only interactions between staff and people were brief. One member of staff spoke with one person about nail varnish and painted their nails. Their only communication with other people was when people were given a cup of tea mid-morning and when lunch was served at 12pm. There were only brief interactions between the people living at the home.

During the morning there was music playing. People were not offered a choice of music. In the afternoon one person received a visitor who spoke with them and others, there were no other activities except the TV. The provider told us that an activity officer visited for two hours a week and a ''music man'' visited for one hour a week. She also said that various volunteers from the local churches visited to meet with individuals.

There was no indication that dementia friendly or sensory activities were organised at the home. Whilst there were books and some games stored in the conservatory, people were not given things to do or interact with.

The daily care notes we looked at did not record a range of meaningful activities.

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

Some people were able to tell us about the things they did to entertain themselves, and were happy with this. For example one person told us they liked to watch DVDs and do colouring books

A relative we spoke to said that they were confident the provider would respond well if they had any concerns and said that communication was good. Another relative said that if they had any concerns they would be able to approach the provider.

People we spoke to said they were happy and knew what to do if they had any complaint. Staff said that they believed the provider would address any complaints that people might have. The provider said that they had not received any complaints.

Requires improvement

Is the service well-led?

Our findings

The provider was unable to locate staff training records, and an up to date training matrix. They could not locate any records of staff meetings, however they did locate some records of supervision undertaken in 2014 but none for 2015. The provider told us that they had started to make improvements to the record keeping. They showed us the Fire Safety file which was clear and organised. A health care professional we spoke to confirmed that at times, organisation and administration could be ''slow and disorganised'', for example delays in registering a new person admitted to the home, or ordering medicines.

Some records relating to care had not been updated such as care plans or were not in place. For example, a person using the service had sustained an injury but there was no evidence that a plan of care was in place in response to this.

The provider had ensured that regular audits were taking place. However, it was clear from the evidence gathered during our inspection that these had not been effective in highlighting concerns. This resulted in the service being unable to effectively assess, monitor or take action when necessary to mitigate against risks to which people had been exposed.

There was a breach of Regulation 17 and Regulation 18(2)(a) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The staff told us that the provider was at the home ''all the time'' and that she was approachable and supportive. They said that she was involved in the day to day care and running of the home. There was a calm atmosphere during the inspection, and the staff we spoke to said they were happy working there. Teamwork was visible, for example, the cleaner and the cook were also both carers and the staff appeared to work well together. However the lack of supervision showed a lack of formal support and staff also did not receive a formal appraisal.

The provider had worked with her team to achieve accreditation in the Gold Standard Framework, which aims to plan and deliver effective good end of life care. The GP confirmed that they were aware of this and were supportive in terms of working with the provider when people reached the end of their life. The provider showed us the coding system they used for the planning of people's care.

The provider had been the registered person and the owner of Blakesley House Nursing Home since 2001 and of a smaller home nearby since 1994. There was a deputy manager who worked at weekends. The provider told us that this was to ensure that there was always someone on site to manage the service. There was also a nurse in charge for each shift.

The provider had notified CQC of any significant events or incidents. This evidence was gathered prior to the inspection.

We saw that the provider had audits in place for medicines and health and safety. These were up to date.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way for people using the service.** **Regulation 12(2)(a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person had not ensured that fit and proper persons were employed because recruitment procedures were not operated effectively and did not include satisfactory evidence of their conduct in previous employment.** **Regulation 19(2) Schedule 3 (4)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users were not protected from abuse and improper treatment because there were restrictions on the service user's liberty.** **Regulation 13(7)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care and treatment was not provided with the consent of the relevant person.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff employed did not receive appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established and operated effectively to assess, monitor and improve the quality of the service or mitigate against risks to people who use the service. The registered person had not maintained secure, accurate and complete records in respect of each service user and the management of the regulated activity. Regulation 17(1), (2)(a), (b), (c) and (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users did not always meet their needs or reflect their preferences Regulation 9(1)