Alston Lodge Residential Home and Community Care Limited

# Alston Lodge Residential Home Limited

## Inspection report

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Tel: 01772783248

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Alston Lodge is registered to provide care and accommodation for up to 17 people who require assistance with personal care. There are fourteen single bedrooms and one double bedroom; six of the single bedrooms have en-suite facilities. Communal facilities consist of two lounges, a dining room and a conservatory. The service has a registered manager; a registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. One of the owners of the home supported us during our inspection visit.

Although risks assessments had been undertaken, the actions to minimise the identified risks had not been undertaken. People were protected from abuse by systems in place; however, staff required further training in all the service's safeguarding policies and procedures. The provider had robust recruitment procedures in place, with a sufficient number of staff and skill mix, however, not all the records relating to safe recruitment were in place. People's medicines were managed by staff who had the competency and skills to administer medication safely. There were sufficient numbers of trained staff deployed to ensure that people had their needs promptly. This was regularly reviewed and adapted to reflect people's changing needs.

The managers understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People's liberty was not unnecessarily restricted and people were fully supported to make choices about their day to day lives. When people had specific physical or mental health needs and conditions, the staff had contacted healthcare professionals and made sure that appropriate support and treatment was made available. Staff understood how to support people who had or did not have capacity to make decisions for themselves. Staff were trained and effectively supported through supervision. People were given choices about food and received a balanced diet. Drinks were available, and support was given when required.

Caring relationships were developed; however, some institutionalised practice meant that some people were not always treated with kindness and respect. We have made a recommendation about this. When practices such as these are identified, staff should have the ability to raise them as a concern and measures put in place find more appropriate person centred approaches. Staff interacted well with people living at the home. People were able to express their views by being involved in discussions, with staff and family members.

Person centred approaches must be adopted when supporting people with behaviour management concerns and needs. People had access to activities that reflected their interests. Further discussion with people at the home regarding the development of the activities programme should take place. We have made a recommendation about this. Resident and relatives knew how to make a complaint and told us they would be comfortable to do so.

There were quality assurance systems in place which monitored people's well-being and safety, however, in some instances, these were ineffective, and therefore, people were put at risk. Although systems were in place for recording and managing complaints; safeguarding concerns and incidents and accidents were not always referred onto the most appropriate social care agency as required. .

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to Safe Care and Treatment, Person Centred Care, Safeguarding people who use the service and Good Governance.
You can see what action we have taken at the end of this report.

## 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.

Although risks assessments had been undertaken, the actions to minimise the identified risks had not been undertaken.

People were protected from abuse by systems in place; however, staff required further training in all the service's safeguarding policies and procedures.

The provider had appropriate recruitment procedures in place, with a sufficient number of staff and skill mix, however, not all the records relating to safe recruitment were in place.

People medicines were managed by staff who had the competency and skills to administer medication safely.

There were sufficient numbers of trained staff deployed to ensure that people had their needs promptly. This was regularly reviewed and adapted to reflect people's changing needs.

### Is the service effective?

**Good**

The service was effective.

The management and staff at the home understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People's liberty was not unnecessarily restricted and people were fully supported to make choices about their day to day lives.

When people had specific physical or mental health needs and conditions, the staff had contacted healthcare professionals and made sure that appropriate support and treatment was made available.

Staff understood how to support people who had or did not have capacity to make decisions for themselves.

Staff were trained and effectively supported through supervision.

People were given choices about food and received a balanced diet.

Drinks were available, and support was given when required.

## Is the service caring?

Requires Improvement

The service was not always caring.

Caring relationships were developed; however, some institutionalised practice meant that some people were not always treated with kindness and respect. We recommended that staff are made aware of institutionalised ways of working, and how these methods and approaches can have a negative impact on people's dignity. When practices such as these are identified, staff should have the ability to raise them as a concern and measures put in place to find more appropriate person centred approaches.

Staff interacted well with people living at the home.

People were able to express their views by being involved in discussions, with staff and family members.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

Person centred approaches must be adopted when supporting people with behaviour management concerns and needs.

People had access to activities that reflected their interests. Further discussion with people at the home regarding the development of the activities programme should take place.

Resident and relatives knew how to make a complaint and told us they would be comfortable to do so.

## Is the service well-led?

Requires Improvement

The service was not always well-led

There were quality assurance systems in place which monitored people's well- being and safety, however, in some instances, these were ineffective, and therefore, people were put at risk.

Systems were in place for recording and managing complaints.

Safeguarding concerns and incidents and accidents were not

always referred onto the most appropriate social care agency as required.

# Alston Lodge Residential Home Limited

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection took place on 07 December 2015 and was unannounced. It was carried out by the lead social care inspector for the service, and an additional adult social care inspector.

At this visit we reviewed the records we held regarding the operation of the service prior to our visit. We also reviewed the information we held about safeguarding incidents in the home. During this inspection we spoke with six people who lived at the home, three visitors, three members of staff, the registered manager and one of the owners of the home. Conversations took place with people in their own rooms, and in the lounge areas. We observed the lunch time meals and observed how staff spoke and interacted with people. Some people were not able to explain their experiences of living at the service to us due to their dementia so we observed and spoke with people's friends and relatives. We looked at a number of records relating to individual care and the running of the home. These included five care plans, medication records, three staff personnel files and quality assurance files.

This service was previously inspected on 20 February 2014, and was found to be compliant with the regulations we inspected against.

Requires Improvement

# Is the service safe?

## Our findings

We spoke with seven people who lived at the home. All of them said they were happy living at the home, and said that they felt safe. Some of the people living at the home had difficulty expressing themselves when we asked them about safety concerns, so we spent some time observing people's engagement and interaction. People looked content and happy, and were seen to move around the home freely, interacting with others. One relative we spoke with said, "I do feel (relative) is safe. Staff regularly talk to her, and staff check on her and if she wasn't safe and happy, she would definitely tell me."

On touring the home, we noted that the main lounge was on two levels, with a step dividing the levels. The step was covered with the same carpet as the rest of the lounge. We asked if anyone living at the home had had any difficulty negotiating the step, and the staff member explained that some people had fallen when using the step. We asked to see the home's environmental risk assessment, and it was clear that the step had been identified as a risk area within the home. We also checked the care records of three people living at the home, and found that they had fallen when trying to negotiate the step. Whilst at the home, we witnessed a resident fall when using the step. The person was very shaken as a result of the fall, and was assessed and observed by a visiting community nurse. No injuries had been sustained. We explained that a change in the colour of the carpet used on the step may help people with visual problems to distinguish the two different levels, and so reduce the risk of falls. One of the owners of the home organised for a carpet fitter to visit the home on the day of the visit, and changes to the carpet were made the following day.

Although action was taken to minimise the risk of people falling when moving around the lounge, it was clear from the records that this risk had been identified in May 2015, and that full and proper action had not been taken to minimise or eliminate the risk of people falling. Falls had continued to take place after the risk had been identified. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. The service provider must assess the risks to people's health and safety during their care or treatment, and take appropriate action to minimise or eliminate those risks in a timely manner.

Information held within the records showed that care workers had received training in safeguarding adults during their induction, with, further safeguarding training being provided throughout their employment. Although staff knew how to recognise different types of abuse, they were found to be unfamiliar with the procedures they should follow if they had safeguarding concerns. Staff were aware that safeguarding issues such as financial or sexual abuse allegations needed to be referred to external agencies. However, they were unaware that minor physical assaults between residents at the home, also needed to be referred to external agencies such as the Local Authority. For example, two people living at the home had recently had a minor disagreement, which had resulted in one person slapping another on the arm. The incident did not cause any injury; however, it should have been referred to the local authority as prescribed in their safeguarding procedures. We explained that these referrals were important as they allowed external agencies to check that the home had appropriate protection plans in place to support people in the home, and to ensure that placements were appropriate to people's assessed and on-going care and support needs. This was a breach

of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People living at the home must be safeguarded from abuse and improper treatment, and all incidents must be appropriately recorded and reported to the adult safeguarding team at the Local Authority.

The processes for the safe and secure handling of medicines were found to be appropriate. The service was found to have a clear process in place for the handling of controlled drugs when necessary. The process in place to ensure a person's prescription was up to date and reviewed was found to be appropriate, and took into account their needs or changes to their condition or situation. Information held within the records showed that staff received training in the safe administration of medicines.

Under current fire safety legislation it is the responsibility of the registered manager to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be on the premises in the event of a fire. In order to comply with this legislation, a Personal Emergency Evacuation Plan (PEEP) needs to be drawn up for each individual living at the home. Information held within the care records showed that PEEP's had been completed. The registered manager explained that the staffing numbers and arrangements were reviewed routinely, sometimes on a daily basis, in response to the needs of people who lived at the home.

The systems relating to the safe recruitment of staff were found to be appropriate, however, some records relating to staff employment and character references were not in the appropriate files: record keeping needed improvement. We found information held with the personnel records showed that the service had assessed the character of applicants during an interview process, and had undertaken appropriate safety and employment checks to ensure people were either clear to work in care, or unsuitable for employment. After people were employed, the service provider had a robust procedure in place if they needed to take disciplinary action against a staff member for whatever reason. This included referrals onto other relevant agencies be that their professional body or the Disclosure and Barring Service. We found that all disciplinary action taken against staff was well documented.

We found written records to show what the arrangements were to provide safe and effective care in the event of a failure in major utilities, or other types of emergency. Equipment had regular safety checks and there was a quality monitoring system in place. Records held within the home showed that the fire alarm system had been tested and that staff had taken part in regular fire drills.

Infection control measures were found to be in place. Staff understood the need to ensure proper hygiene measures were followed, and the home had appropriate equipment and cleaning procedures in place.

Good

# Is the service effective?

## Our findings

People who we spoke with at the home had no difficulty in expressing themselves. People were seen to engage with the staff team, and other residents at the home. The staff were seen to interact with people in positive ways, and this showed that they understood how they needed to respond to people's needs.

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. 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.

Assessment and review processes were found to be in place to ensure that staff and relatives were kept up to date with a person's capacity issues, and to ensure that staff followed the correct procedures when supporting people who lacked capacity. We found documentary evidence to show that the systems operated within the home relating to consent to care and treatment took into account both local and national official guidance. Where needed, mental capacity assessments took place; best interest meetings were convened and referrals to the Local Authority were made if a DoLS was required. The staff we spoke with understood the need to ensure people were enabled to give consent to care. They understood the requirement to seek external advice and guidance if there were any doubts about a person's ability to make informed decisions.

The staff team knew people well and knew how they liked to receive their care and support. The staff were knowledge about how each person liked to receive their personal care and what activities they enjoyed. Staff were able to tell us about how they cared for each person on a daily basis to ensure they received effective personal care and support. They were able to explain what they would do if people became restless or agitated or if they were sad and needed comfort.

The registered manager explained that the service had a training programme for staff to follow. Staff with particular roles within the home, such as the administration of medicines, were provided with further training, and staff told us they received update training as required. Although the records showed that there were gaps in some staff training updates, there was an action plan in place to address this. Information held within the personnel records showed that there were processes in place to assess if the staff were competent to deliver care and support to people living in the home. The registered manager explained that supervision arrangements were in place and the records confirmed this. The staff we spoke with said that they received formal supervision during which they could discuss their role and work, and identify their learning and development needs.

We found documentary evidence to show that on-going assessment, planning and monitoring of nutritional and hydration needs and intake took place. We observed that food and hydration was provided and made available in sufficient quantities and on a regular basis, and this was supported by comments from people living at the home. We found there to be a choice of food and drink that took account of people's individual preferences. People said that they could decide when to eat and where to eat. We observed staff offer support to enable people to eat and drink when necessary. This was found to be documented within the individualised care plans. We found information to show that some people had been assessed as being at risk of losing weight and of dehydration. Systems were found to be in place to monitor and manage these risks, and record keeping was both accurate and up to date. When people had problems eating and drinking they were referred to dieticians. People who had difficulty swallowing were seen by the speech and language therapists to make sure they were given the correct type of food to reduce the risk of choking.

People's health was monitored and when it was necessary health care professionals, like doctors and district nurses were involved to make sure people were supported to remain as healthy as possible. People were supported to attend appointments with doctors, nurses and other specialists if they needed to see them. People experienced positive outcomes regarding their health. Staff were proactive when people needed health care support, for example, a person had lost a lot of weight before coming to the service. The staff immediately started giving them fortified foods. The dietician was contacted and a swallowing assessment was carried out by the speech and language therapist. The person started to put on weight immediately.

Requires Improvement

# Is the service caring?

## Our findings

The atmosphere within the home was warm, welcoming, friendly and calm. All the people and visitors we spoke with were positive about the care received. One relative said, "They (the staff) treat people very well here. I've never had a grumble and I've never heard (my relative) grumble. I'm sure that if the staff were not caring then (my relative) would be the first to complain." Other comments included, "We all love the staff: they are great.", "They are all lovely and you can have a chat with every one of them." Our observations showed that staff cared for people and attended to their requests. For example, one person was distressed and a care worker responded to the person quickly. They talked with the person and asked how they were. They gave time for the person to talk and engaged with them.

We observed that nurse call bells were responded to which was confirmed by people. One person said, "If you press the bell they're here straight away." Another said, "My doctor was here and he set the buzzer off by accident. There were 2 staff here in seconds: the doctor was quite embarrassed!" People's bedrooms were personalised and contained photographs, pictures, ornaments and other items each person wanted in their bedroom. This showed that people had been involved in establishing their own personal space within the home.

We looked at the ways in which people were supported to understand the choices they had that were related to their care and support, so that they could make their own decisions. We spoke to four people at the home who said they were comfortable when expressing decisions about their care. One person said that they could approach the staff or manager to discuss issues such as their food, clothing and medication. We spoke to a visitor who was visiting their relative and they told us that they felt they could influence the care and support their relative received if there were problems, and explained that they had been involved in significant decisions about their relative's healthcare. We found documentary evidence to support this in the care plans and risk assessments. However, as detailed within the Responsive section of this report, the institutionalised use of name tags on dining rooms chairs, when dealing with behaviour manner issues was not seen to be a dignified and respectful way to support people.

We toured the home when we first arrived, and the staff member who guided us was observed not to knock on people's bedroom doors as she entered them. Staff talked with people and involved them in activities such as setting table's for lunch. Care workers used people's preferred names and we saw warmth and affection being shown to people. People recognised care workers and responded to them with smiles which showed they felt comfortable with them. Tasks or activities were seen not to be rushed and the staff were seen to work at the people's own pace. We observed lunch times in all dining rooms. Tables were set nicely with cutlery and crockery, condiments and napkins. Food was well presented and looked appetising. Staff had a gentle approach and were unobtrusive but provided support and prompts for people when it was asked for or at appropriate times.

People were involved in decisions about their end of life care. For example one person had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw the person and their family were involved in this decision. Although

staff had not received specific training in end of life care, when questioned, their answers showed an understanding of the need to be sensitive to people's end of life needs, and were happy to support people according to their wishes. As the home did not provide nursing care on site, staff recognised that there may come a point when a person may need to leave the home in order to be cared for at a different facility. If this was to happen, one staff member said, " We would look after that person up to the second they left us, and make their time with us as comfortable as possible."

We recommended that staff are made aware of institutionalised ways of working, and how these methods and approaches can have a negative impact on people's dignity. When practices such as these are identified, staff should have the ability to raise them as a concern and measures put in place to find more appropriate person centred approaches.

Requires Improvement

# Is the service responsive?

## Our findings

When we toured the building, we noted that the dining room chairs and tables had name tags on. These tags were the names of various people living at the home. We asked a senior staff member about this, and they explained that the tags had been put on the furniture by the deputy manager, who had recently left the employment of the service. When asked why it was necessary to put name tags on tables and chairs, we were offered the following explanation. "Some of the residents don't get on with another, and they sometimes argue and lash out. So to minimise the possibility of this happening, we make sure that some residents don't sit next to or near to each other, and the name tags are a reminder to staff."

We spoke to one of the owners of the home and registered manager about this approach to behaviour management and personality clashes, and explained that it was not a recognised person centred technique. They both agreed, and the tags were removed. We explained that when dealing with personality clashes or behaviour management, a more person centred approach would be to devise an individual care plan that highlighted triggers for a person, and the response and strategies staff should employ to minimise any risks or escalation in behaviour. One of the owners of the home explained that these plans were in place, and we saw an example of one. She added that more work needed to be undertaken with the staff team to ensure that they were fully aware of the care plans, so that a more person centred approach could be offered. The use of name tags on furniture was seen to be an institutionalised approach to dealing with behaviour management, and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred approaches must be adopted when supporting people with behaviour management concerns and needs.

Information held within the care plans showed that people had been involved in their assessment of need, depending on their capabilities. This process helped to identify their individual needs and choices, and was based on information supplied by social workers or healthcare staff. If the person was unable to contribute, information had been actively sought from others such as family members and friends. Written personalised care plans, which detailed people's individual needs and choices, had been put together by the staff and the person in receipt of the care where possible. People had a range of care plans covering needs relating to cognition; wheelchair use; personal hygiene; diet and fluids; dehydration, social activities; sleep; continence; falls; mobility; hearing and sight. These care plans were personalised.

Care plans were evaluated on a monthly basis and some contained very individual information such as people's preferences in relation to clothing and how they liked their room when they go to sleep. The reviews showed that where possible, the person themselves had been involved, and if this wasn't possible, family members and others important had been consulted.

The staff we spoke with understood the importance of involving people in appropriate activities which helped people feel involved and valued. Staff told us activities were based on people's preferences. For example there were one to one activities such as talking about the news, reminiscence, arts and crafts. The daily notes in the care plan recorded what activities and events the person was involved in. Two people living at the home said that there weren't enough activities on offer at the home. One said, "Although we do

have things to do, there are times when the only thing to do is watch TV. It's OK I suppose, I think they could offer us a bit more." We had made a recommendation about this.

The home has a suitable complaints policy and procedure that is publicised in its 'Statement of Purpose' and this documentation was provided to new people entering the home. The home had appropriate processes in place to ensure that when people were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between providers and services. Information held with people's personal care records showed that liaison had taken place with other health professionals and a relative spoken with confirmed that they had been involved with the assessment process and had been kept informed at every stage. Staff at the home stated that confidential information was only shared about a person once it was established it was safe to do so. We observed this in practice when a staff member spoke to a relative over the telephone regarding a sensitive healthcare matter.

It was recommended that discussions take place with people at the home regarding the development of the activities programme.

Requires Improvement

# Is the service well-led?

## Our findings

People, their relatives and staff said that the managers were approachable and supportive and they could speak to them whenever they wanted to. People and their relatives told us the managers listened to what they had to say and 'sorted things out' if there were any problems. The staff said the managers always dealt with issues in a calm and fair way. On the day of the inspection people, relatives and staff approached the managers whenever they wanted to. There was clear and open dialogue between the people, staff and the managers.

We found documentary evidence to show that risk assessments and safety plans were in place relating to different aspects of the home. For example: care planning, treatment, infection control, medication, healthcare, environmental safety and staff training. However, the process for ensuring that these assessments were followed were not robust. We saw that records of incidents and accidents were kept. However, we noted that although risks to service users had been identified, prompt action had not been taken by the registered persons to minimise these risks, and some residents had experienced falls, and experienced harm and discomfort that could have been potentially avoidable. Institutionalised ways of working were seen to be in operation, and although senior staff were aware of this, nothing had been done to tackle these practices. For example, name tags on dining room chairs, and also safety concerns regarding the step in the lounge.

Staff confirmed that they received handovers (daily meetings to discuss current issues within the home). They said that handovers gave them current information to continue to meet people's needs, and updates regarding incidents. We found written evidence to show that the service had a system in place to assess and monitor the quality of the service. The deputy manager and administrator explained that they were involved in auditing different aspects of the services provided. We saw evidence of these audits, and saw that the system had flagged up areas of concern, and minor issues relating to care delivery and service provision. However, we noted that the registered manager audited the medication on a six monthly basis. We asked if she thought that this timescale was too long to identify medication errors or discrepancies, and she agreed that a monthly audit would be more appropriate. This reduced timescale would help to pick up on problems with medicines and their administration in a more timely manner.

The managers attended local network meetings and provider forums to help stay on top on best practice. They researched what was available through a variety of training providers to ensure they had the best training packages for staff based on best practice. Despite this, managers were not fully aware of the fundamental standards for care homes and were not up to date with changes to legislation. Some notifications regarding potential physical assaults between residents due to personality clashes or behaviour management had not been referred to the local authority and the Care Quality Commission.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must ensure that there is a robust system in place that can be effectively used to monitor the quality of the service provided, and ensure it is provided safely. Record keeping and referrals must be more accurately maintained and processed in order to ensure all the right

information is supplied to the relevant social care agencies.

We observed the deputy manager and staff talk to people throughout the day and they spent time ensuring people were content and happy with the service they were receiving. We found that an annual questionnaire was delivered to the people supported by the home, relatives, and local health professionals. The results of the questionnaires and any recommendations were looked at by the management team and put into action. The feedback from the latest set of questionnaires was found to be positive with no recommendations.

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 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 | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Person centred approaches had not been adopted when supporting people with behaviour management concerns and support needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The service provider had not prevented people from receiving unsafe care and treatment and, had not prevented avoidable harm or risk of harm. The service provider had not adequately assessed the risks to people's health and safety during their care or treatment, and had not taken appropriate action to minimise or eliminate those risks in a timely manner. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The service provider had not properly safeguarded people from potential abuse, by not correctly reporting incidents such as minor physical assaults between people living at the home. |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The service provider had not ensured that there was a robust system in place that could effectively monitor the quality of the service provided, and ensure it was provided safely. Record keeping and referrals were not accurately maintained and processed in order to ensure all the right information was supplied to the relevant social care agencies at the right time.