Venn Care Ltd

Venn House

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**

Summary of findings

Overall summary

The inspection took place on 5, 8 and 20 January 2016. The second day included an evening visit. The first two visits were unannounced but we gave short notice of the third visit because we needed to be sure that the provider would be available. Our previous inspection, April 2014, found the standards we looked at were being met. We brought this inspection forward because we had received concerns about staffing at the home.

Venn House is registered to provide accommodation and personal care to a maximum of 25 people. It is not a nursing home. The accommodation is over two buildings, the Coach House and the main house, on the one site. There were 12 people in the main house and six people in the Coach House when the inspection began.

The service is required to have 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 2008 and associated Regulations about how the service is run. Venn House has a registered manager but they have not been in day to day control of the service since August 2015. They have not yet removed their name from the register.

People were not benefitting from a stable management of the home because it had been managed by three consecutive managers in the last five months. The last ended their employment during the inspection. People said they were not sure who was running the home. However, a new manager was due to start on 22 January 2016.

There were no embedded systems to monitor the quality and safety of the service. This meant risk was not always identified and managed so people were protected.

Staffing arrangements did not always ensure people were safe and there had been an increasing number of falls at the home. Although steps had been taken to mitigate risks to individuals, and staffing numbers had increased, this had not fully protected people. Risk assessments were not always reviewed. New risks had not been assessed taking into account the vulnerability of individual people, such as moving to the new Coach House. Prior to moving to the new Coach House people were living in premises not safe for their use, including damp. The new Coach House provided a home for people with dementia based on research into suitable dementia friendly environments.

People's legal rights were not always upheld because they were not free to leave the home and were under constant supervision. Some applications to deprive people of their liberty had been requested for their safety and welfare, in line with the Mental Capacity Act and deprivation of liberty safeguards. Decision making arrangements were in place where needed, in line with the principles of the Mental Capacity Act.

Staff did not receive regular supervision or appraisal of their work and so training needs and support might not be identified. Staff training had lapsed but was being reorganised and updated.

People received their medicines as prescribed and when needed but records were not always completed and audit of medicine use not always available. We have made a recommendation about the management of some medicines.

People's needs were assessed and their care planned with them or a family member. Staff knew people's needs well and provided person centred care when they were able. People had interests which they followed, such as reading and quizzes an some activities were provided, but with people's increased frailty some had only limited company, when staff had time. We have made a recommendation about activities to prevent isolation.

Staff were kind, friendly and treated people with respect and dignity. They showed great concerned for people's welfare. People said of the staff, "Wonderful"; "The carers are very nice" and "They've made me feel very welcome." Community health care professionals said the staff contact them in a timely manner for advice and to provide health care to people.

People liked the food which they described as, "Very good; enough quantity and variety". People had choices, assistance where required and meal times were friendly and sociable occasions.

Staff recruitment protected people from staff who might not be suitable to work with vulnerable adults. The staff knew how to protect people from abuse and harm.

There was a complaints procedure should people wish to complain. There had been no recorded complaints at the service.

We found four breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back 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

Some aspects of the service were not safe.

Staffing arrangements did not ensure people's safety or welfare needs were met.

The premises was not safe for some people and risk had not been under review.

Staff were recruited following checks on their suitability to work with vulnerable people.

Staff new how to protect people from abuse and harm.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

There were no arrangements for regular supervision or appraisal of staff for their support.

Staff training had lapsed but was under review although staff had the knowledge and skills to provide effective care.

Some people were deprived of their liberty unlawfully although this was done for their safety.

People consented to their care and some decisions had been made in their best interest where they lacked capacity to make informed decisions themselves.

People enjoyed the food and benefitted from a varied and tasty menu.

People's health was promoted through timely contact with community health care professionals.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and respectful to people.

People's privacy and dignity were upheld.

Staff engagement with people was of a high standard which made them feel valued and supported.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care needs were assessed and a plan of care in place but these were not always reviewed in line with the review date or when people's needs had changed.

A lot of information was provided on how complaints could be made and would be handled but the information varied and could cause confusion.

People who could comment were very satisfied with the way they spent their time. Some people were more isolated and lacked company or activities of interest to them.

Staff were very responsive to people's needs and were aware of when a person's health was a concern.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

People were not benefitting from a stable management of the home.

There was not a systematic approach to assessing and monitoring risks to people's health and safety.

People's views were sought toward review of the quality of service provided.

Venn House

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.

The inspection took place on 5, 8 and 20 January 2016. The second day included an evening visit. The first two visits were unannounced but we gave short notice of the third visit because we needed to be sure that the provider would be available. During the inspection people moved from the original Coach House to a new Coach House building.

One adult social care inspector completed the inspection.

A Provider Information Return (PIR) had been requested prior to the inspection. 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. The provider was unable to provide the information within the timescale.

Before our inspection, we reviewed information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We spoke with seven people using the service, three people's family and a visiting friend. We looked at the care plans and risk assessments for four people and some medicine records. We spoke with seven staff members and the registered provider. We looked at records connected with how the home was run, including staffing rotas, training records, records of a staff meeting and questionnaires people had completed. We looked at risk assessments for both the Coach House and main house. We spoke with one

community health care professional.

Requires Improvement

Is the service safe?

Our findings

We received concerns about staffing arrangements at Venn House prior to this scheduled inspection.

The arrangements for making staffing decisions did not adequately promote people's safety and welfare.

The usual staffing arrangements were that care workers were responsible for laundry and preparing and serving afternoon tea, supper and evening drinks in addition to tasks related to providing care.

One of the six people in the Coach House and four of the 12 people in the main house required two staff to meet their personal care needs. Records showed, and staff confirmed, that on occasions night staff left one building to assist in the other building, leaving one building without a staff member present. An audit showed increasing levels of falls at the home. There were five accidents/falls during the day of our first visit and we made staff aware when a person, with a history of falls, was intent on leaving the building.

The provider had increased the numbers of care staff to work on some of the evening shifts. But this did not include each shift. There was a plan to increase night staff from two to three, which started during the period of the inspection but did not include every night.

People using the service did not express any concerns about staffing numbers, one saying, "(Staff) come straight away" and they felt safe at the home. People's family members expressed concern. One said, "Many times I've physically helped people"(when staff were not around). Staff said they were very concerned about the staffing arrangements, feeling people were at risk.

The second day of our inspection we told the provider our concerns about the staffing arrangements. When we conducted our third visit people had moved from the old Coach House to the new Coach House extension. There was one care worker throughout the 24 hour period with an arrangement to call for assistance when double handed care was needed. A care worker came from the main house to assist when a person wanted to move from the dining room to the lounge. Otherwise we saw the one staff member trying to support people with dementia over the two floors. When the care worker was out of hearing and sight, one person was wandering, opening drawers in a lounge and then they went into another person's bedroom. Had the person opened the external doors, which were next to and also in their bedroom, they would have left the building unseen by the staff member, increasing the risk of harm. A person's family said, "When in the (old) Coach House if mother shouted staff would have heard". They felt this was not the case in the new Coach House. They did not think their family member would be able to use the call pendant they had available to call for assistance.

The provider said staffing numbers were decided from feedback from staff and the identified risks from risk assessments. However, there was no risk assessment based on the individual needs of people when moved to the Coach House and, although staff concerns had led to improved staffing numbers, the arrangements did not keep people safe. The provider said they would review people's safety as a priority.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

The previous manager had undertaken an audit of accidents which occurred at Venn House during 2015. There was an increase in accidents to people using the service between the January (4 accidents) and December 2016 (20 accidents). Where increasing risk to a person was recognised steps had been taken to protect the person. For example, tests for infection, consulting occupational therapists and a 'gate' to prevent one person falling down the stairs. However, assessments of the risks were not always reviewed. For example, one person had sustained a fracture following a fall on 15 September 2015. Their records showed the last fall risk assessment was 9 September 2015 although according to their care plan there should have been a "weekly review".

During our inspection a staff member was completing an accident form as they had "hurt their back" moving a person's bed away from a water leak in their room. One accident form described staff slipping by the front entrance. The risk assessment for the front entrance had not been reviewed since 15 October 2014 and, according to that assessment, should have been reviewed 'six monthly'. There was a building/general risk assessment completed for the new Coach House and, following our feedback, the provider said the main house assessment would be "reviewed shortly".

People were not always safe on the premises. Before people moved to the new Coach House some were using freestanding radiators in their rooms. We checked one to see if the risk from this had been assessed. The fire safety risk assessment, dated 20 April 2014, did not relate to the same person using the room and did not specifically mention freestanding heaters. A level of risks might not therefore be known or managed for the person's, and others, safety. The provider said there were no individual evacuation plans for people, to inform the emergency services about people's needs in the event of an emergency.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Medicines were stored safely according to specific requirements, for example refrigerated or additionally secure storage. Medicines were delivered to people as required and signed for when taken. The medicine records were colour coded for clarity when administering the medicines. There were measures in place toward safe management of medicines. These included a photograph of the person to whom they belonged and a record of why a medicine might not have been taken, for example, "spat it out".

The record of checking medicines into the home was not being kept as part of a medicines audit; the staff signature was on the box the medicines were received in, which was discarded when empty. There were gaps where a medicine was not a tablet, for example, for ear drops, which meant the review of the medicine use could not be clear as to their effectiveness. Training records showed that staff who administered medicines had a supervised observation during 2015 to check their competence. There had been an audit by a pharmacy May 2015. It was not clear whether action points from that audit had been followed up and the manager said they had found no information about this.

We recommend the service follows the NICE National Institute for Health and Care Excellence Guideline, Managing Medicines in Care Homes Published 14 March 2014.

One person had commented in the home's October 2015 quality assurance survey, "The Coach House has been in a state for a long while now…" The move to the new Coach House went ahead on 12 January 2015. Although due for renovation, people were living in unsatisfactory accommodation until that move. For

example, the person whose bed was moved due to a water leak had a damp and mould marked wall very close to the head of their bed and there was mould around a lounge window. The laundry room, external to the accommodation, although not purpose build and not readily cleanable, at this visit contained dust covered cobwebs hanging over the clean laundry. There was also mould around the window. A domestic worker said that she could not reach the high areas in the laundry room but this was sometimes cleaned by a different member of staff. The provider assured us the laundry upgrade would be completed within three months and where the mould and damp was found, the leaking roof repair was arranged prior to Christmas.

The information from which recruitment decisions were made was based on checks before new staff started. Each person had completed an application form, had references and a DBS check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, the request for one of the references incorrectly stated the person had applied for a job as the registered manager, not a care worker.

We asked the provider what measures were in place in case of emergency. At the time they could not locate a list of contacts for staff to use in case of a failure, such as breakdown of equipment, but said they were always available with the information, which they then sent us. Some staff had received training in first aid and there was first aid training planned for the near future. An 'on call' staff member was available for night time emergencies.

Staff had a good understanding of abuse and how to respond should they have any concerns. One said they would contact the manager, provider or "the authorities". A file of concerns had been compiled in a file called 'Safeguarding' by the manager since their employment in November 2015. There was a handbook on how to alert concerns displayed in the office plus the contact details for the local authority safeguarding team. Staff said they had received training in how to protect people from abuse; records confirmed this. The manager said, "Staff will speak up when seeing any poor practice."

Requires Improvement

Is the service effective?

Our findings

The staff, who were experienced care workers, told us they had received sufficient induction when new to the home including shadowing senior care workers for two weeks of shifts. This meant they had started the process of understanding the necessary skills to perform their role appropriately and to meet the needs of the people living in the home. However, two care workers said they did not know where they would find policies and procedures should they need to consult them. The manager said that use of the Care Certificate, a nationally recognised induction for staff who are new to care, was not in place.

Staff told us training at the home had lapsed but there were now improvements. For example, there had been recent fire safety training although records showed some staff had failed the training. Some training was advertised, such as first aid. The Venn House training spread-sheet showed lapses in essential training. For example, one cook had no food hygiene training recorded and the second cook's food hygiene certificate was out of date. They confirmed this was the case. All care staff prepared and handled food but no in-date food hygiene records were found. Other training needs, which were not being met, included health and safety and safe handling of chemicals. Staff confirmed they received training in some aspects of health and safety, such as moving people safely, first aid and infection control, although this information was not part of the training spread-sheet.

Supervision provides an opportunity for staff to discuss work and training issues with their manager. It also provides the manager with an opportunity to feedback to staff issues around their performance. Some staff had some supervision of their work but staff did not receive on-going supervision or periodic appraisals because time had not routinely been set aside for this on a planned basis. This meant the provider could not demonstrate how, or if, the competence of staff had been assessed or maintained.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

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 interest and as least restrictive as possible.

People were encouraged and supported to make informed decisions about their care. For example, one person liked to be surrounded by their belongings but understood they might pose a risk because the room was somewhat cluttered. Records showed that some people's capacity to make particular decisions had been assessed using the principles of the MCA.

Some people had authorised others to act on their behalf and the staff had the relevant information available for them to check what was agreed under that authorisation. Where necessary best interest decisions had been made which were the least restrictive for the person.

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 home are called Deprivation of Liberty Safeguards (DoLS). DoLS authorisations had been requested for two people for their safety and well-being. The manager had taken the correct steps to uphold those people's legal rights. They were aware that some other people in the home required an application under DoLS as they were not free to leave and were under constant supervision. For example, living behind coded doors. Those DoLS applications had not been made and so those people were being deprived of their liberty unlawfully.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

People spoke very highly about the care they received with comments including, "I'm cared for very well" and "The care is amazing." Care workers were confident and skilled when assisting a person from the floor using a hoist. They ensured the person understood what they were doing and what to expect. They continually checked they were comfortable and felt safe and secure.

People received a nutritious diet about which they were very complimentary. Their comments about the meals included, "A very good cook"; "Very good; enough quantity and variety" and "They feed me very well." Where there were concerns about people's diet staff monitored this. Where there were concerns that a person might choke specialist advice had been sought and was staff followed it. An example was thickened drinks.

Some people chose to eat in their room and others were seen enjoying the social aspect of eating with friends. Care workers discreetly assisted those people that required help. Drinks were available in people's rooms and regularly offered in addition. Staff said food was available any time night or day and one person said they had been brought a hot chocolate drink when they could not sleep.

People received the health care they required. Local GPs and community nurses visited the home. One said, "The care girls here…identify problems at an early stage and are proactive at contacting us." Records showed involvement from other relevant health care professionals such as physiotherapists and community psychiatric nurses.

Good

Is the service caring?

Our findings

Care workers were kind, gentle and showed much concern for people's well-being. One care worker recognised a person was acting out of character during lunch. They kept returning to ask how the person felt. When the person had eaten what they wanted the care worker took them to rest on their bed. Two care workers assisted a person who had fallen. Their engagement with the person, who was living with dementia and appeared very confused, was of a high standard, providing reassurance and encouragement.

People were treated with dignity and respect. For example, they were consulted about how they wished to spend their time and live their lives. One person chose to live surrounded by items of personal value although this posed a problem of clutter with some risk.

People and their family members praised the care workers. Their comments included, "Wonderful"; "The carers are very nice", "They've made me feel very welcome" and "It is a friendly environment." People's family members appeared at home, making themselves drinks in the kitchen and chatting casually with people and staff. They said they visited when they wished and there were no visiting restrictions.

People had individual rooms which were personalised and contained their furniture and items of importance to them, such as books and photographs. Each person's door had a sign which when used indicated care was being provided and entry was restricted. This helped to ensure people's privacy was maintained. Staff knew people's likes and dislikes well. People told us their views on how they chose to live their life were respected by care workers and they were treated with dignity and respect.

People's views had been sought through a survey of opinion in October 2015. Some negative responses related to the home environment. The provider said no action had been necessary based on the results (as the building was due for renovation). One person had commented, "They respect my independence".

Thank you cards, recent to the inspection, included, "Wonderful care"; "A great comfort" and "How cherished mum became by all the staff."

Requires Improvement

Is the service responsive?

Our findings

There was information displayed in various places telling people and their families how they could complain if they were unhappy. The information contained contact details of the provider and the Care Quality Commission. Although the information people needed was available it was not all to be found in the same place, which was confusing. The provider said he was "not aware of any complaints" and the manager had no information about any.

People received care which was, where possible, centred on them as an individual. One care worker said, "All residents get choice although there are staff task lists". They confirmed the lists were not adhered to against people's wishes. For example, staff changed the date a person had a bath. However, recently introduced 'handover sheets', used to inform the next shift of staff including agency workers, lacked detail. For example, one said "No concerns" but gave no other information about the person. An agency worker said there was a routine she was to follow but she had been at the home several times, checked with other staff and had got to know some people.

Each person's needs had been assessed prior to their admission. From that assessment a care plan was produced. Care plans are a tool used to inform and direct staff about people's health and social care needs. Whilst care plans informed staff about people's individual needs and preferences, an example being 'It is very important (the person's) medicine is given on time' some information relevant for people's needs was missing. For example, information specific to the hoist and sling people required for staff to move them safely.

Some people's care plans had recently been reviewed but some were not reviewed in line with the review date recorded. This had the potential to lead to inappropriate care being delivered if the person was unable to express their preference at the time. People were involved in planning their care, or their family on their behalf. Care plans relating to people in the Coach House were kept in the main house, and so not available for the care worker delivering that person's care.

People's care plans contained some detail about the person's history. This helped care workers to plan the person's care in line with their needs, for example, faith needs. People told us they were satisfied with the way they spent their days at Venn House. People met socially over lunch in the 'country kitchen' dining room in the main house. Some had books and magazines which they said they enjoyed, or television and music. The manager said a person visited to provide armchair exercises and individual time with people in their rooms. However, staff worried that some people became isolated in their rooms as their frailty increased. We saw people sometimes lacked company or had any activities or stimulation to occupy them. For example, one person wandered between rooms and another sat passively in front of a television which they were not watching. One person said, "I have nothing to do today but look out of the window". A care worker said, "There are too many people needing two carers. We can give them no time".

We recommend that the service finds out more about current best practice, in relation to preventing isolation and the specialist needs of people living with dementia.

Requires Improvement

Is the service well-led?

Our findings

People were not benefitting from a stable management of the home. The service had been managed by three consecutive managers in the last five months. The registered manager had been in post for many years but left in August 2015. This was followed by a new manager and then another who started at the home on 16 November 2016. When we conducted our third inspection visit there was no manager in post. People said they were not sure who was "running the home". The provider said a new manager would be starting on 22 January 2016.

The provider had not submitted a Provider Information Return (PIR). This was due by 15 January 2016. When we conducted our first visit we asked about the PIR and the provider was unaware it had been requested. Later the request was found but they had been unable to submit the information. It would have arrived in time if they had been successful in submitting it.

People were not benefitting from effective and embedded systems for monitoring the service. The provider said they assessed and monitored the quality and safety of the home by two methods. The first was through quality assurance surveys for "residents and relatives/friends and advocates" the last one being October 2015. The results had been collated and most were positive. Negative comments were centred round the home environment, which related to the Coach House, which was being upgraded by the end of the inspection. The opinion of staff, health care professionals and other stakeholders in the service had not been surveyed. There had been a staff meeting in November 2015 where the then new manager had introduced them self but there was no regular arrangement for staff to feedback their opinion.

The second method of quality assurance was said to be the monitoring of safety on a daily basis "in regard to the personal care of each resident and in regard to the safe environment". Some care plans had been reviewed following a change in people's needs and action taken to mitigate risks. However, some care plans had not been reviewed according to their review date, following a change of needs or move to the new Coach House. Also, risk assessments for the premises were found to be out of date and not relating to people's individual needs and assessed risks.

Audit is a tool which provides a systematic approach to the monitoring of quality and safety. Only one audit was found undertaken at Venn House and dated January 2016. This related to accidents during 2015, which showed a gradual increase. Staffing had then been reviewed following the result. However, there was not a tool or system used to plan staffing numbers. The provider said, "If anyone has an issue with anything I listen and do it. I do not make a note of things I just do it". They said that people's family had always been encouraged to email any queries or issues. However, this approach had not ensured effective planning, or delivery of staff training and supervision. It had not ensured risk management reviews had taken place, or people living with dementia in the Coach House would be safe.

We were shown the action points arising from a medicines check list dated May 2015. One action was to 'consider using supporting audits monthly, as they give good evidence of medicines management'. There was no information to suggest this had been done.

Some policies and procedures had been reviewed in 2015 but some did not provide the necessary information for staff. For example, the only information for staff about infection control we were shown was found within a policy we were shown on health and safety. It provided very little information about what the policy was or provide a procedure to reduce the possibility of cross contamination. For example there was nothing on the cleaning of hoists, wheelchairs, slings or the laundry room. A domestic staff said they kept their own record of which rooms they had cleaned and when.

No shared vision or values for the service was evident. Staff expressed considerable concern for the welfare of people using the service and the lack of continuity of management was raised by people using the service, their family members and staff. A community professional said, "The ethos has to come from above".

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

The provider told us of their plans for improvement. These included finding a proven quality assurance system to implement and looking at whether a computerised system would flag up any risk or concerns to be acted on. Improvement in the standard of premises was underway according to the plans for the upgrading and eventual increase in resident numbers. Advice on suitable environments for people living with dementia had been taken when planning the new Coach House. The provider had quickly engaged a new manager who they said would be supported to establish the systems where needed to ensure a safe and well-led service for people.

People were very complimentary about the home. Their comments included, "The home is brilliant" and "I can't think of anything to improve."

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 12 HSCA RA Regulations 2014 Safe care and treatment There were risks to people's health and safety which had not been assessed, or managed. This is a breach of Regulation 12 (1) (2) (a) (b) (d)

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 People were being deprived of their liberty without lawful authorisation. This is a breach of Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was not an established and systematic approach to monitoring the quality and safety of the service. This is a breach of Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements did not ensure people's safety and welfare were promoted.

This is a breach of Regulation 18 (1) (2) (a)