

Abbeyfield Society (The)

Abbeyfield - Richard Cusden

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 18 and 22 February 2016. The first day of the inspection was unannounced, the provider knew we would be returning on the second day. This was the first inspection of this service since it registered with the Care Quality Commission (CQC), it was previously registered under a different provider.

Abbeyfield - Richard Cusden provides personal care for up to 22 older people, including those who may have dementia. It is located near Streatham and Tooting, South West London. At the time of the inspection there were 22 people using the service, 16 females and 6 males.

There was a manager at the service; they were in the process of applying to become the 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.

People using the service told us they were happy living at the home and that they were fond of the care staff and other people at the home. They told us that staff treated them well and they felt safe living there.

Care workers demonstrated to us that they knew about people, their preferences and their behaviours. They were able to recall details about people's history that was documented in their care plans.

We saw some good examples of a caring attitude between care workers and people using the service, for example care workers spent time speaking to people and if people needed some support they were quick to respond. However, we also saw some instances where the care provided could have been better and where people were not supported as they should have been.

People's support needs in relation to their medicines and health were being met by the provider. People were registered with a GP and were visited by a district nurse if they needed nursing care. Medicines practice at the home was robust.

People were offered a choice in relation to their meals which was prepared using fresh, good quality ingredients. Although there were concerns raised about the length of time the service was without a permanent chef, we saw evidence that the manager was in the process of recruiting a chef and assistant.

The provider was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The provider followed guidance where people that who did not have the capacity to understand decisions related to their care and where restricted in their movements and had applied to the relevant authorities to do so legally. However we found that one person's authorised DoLS had expired.

Staff recruitment at the home was robust and staffing levels were sufficient to meet people's needs. However, we saw on occasion that staffing levels had not been at the required level in the weeks leading up to the inspection which could potentially have impacted on the care provided.

We found significant gaps in the training provision for staff. There was a lack of training specifically in dementia awareness, MCA/DoLS and care planning.

We found that risks were not identified correctly in all cases, and were therefore not adequately mitigated against. People were at risk of not having their needs met as care plan documentation was not always fully completed or up to date. Some needs assessments had not been fully completed, care plan evaluations did not always accurately reflect people's changing needs, and outcomes and people's wishes were not always identified to be followed up.

There was a lack of quality monitoring within the home aside from medicines audits which were thorough.

The home had been taken over by a new provider in December 2014 and there was a long delay before they had notified the CQC of this. There had been some recent safeguarding alerts which CQC had also not been notified of. A new manager had recently started in January 2016 and an existing senior member of staff was acting up as the deputy. We found that staff morale was low and some staff told us they were not always kept informed of changes within the organisation.

The manager was aware of the issues we found at the home and told us that she was determined to correct these.

During this inspection we found breaches of Regulations relating to safe care, staffing, care planning, notifications and good governance. You can see what action we told the provider to take at the back of the full version of the 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.

Risk assessments were not always completed correctly which meant they did not always reflect people's support needs.

People told us they felt safe living at the home.

Medicines management at the home was safe and regular audits took place.

Staff recruitment checks were robust. Staffing levels at the home were sufficient, however on some occasions leading up to the inspection we saw they had dropped below the normal levels.

Is the service effective?

Requires Improvement ●

The service was not effective in some aspects.

We found significant gaps in staff training.

People had their healthcare and nutritional needs met.

The provider was meeting the requirements of the MCA and DoLS, however care staff understanding was limited.

Is the service caring?

Requires Improvement ●

Some aspects of the service were not always caring.

Staff interactions with people were good.

People told us that staff were kind and considerate.

However, we saw some examples where people were not supported in a manner that was consistent with good care.

Is the service responsive?

Requires Improvement ●

The service was not responsive in some aspects.

Care plans did not always fully reflect people's individual needs.

A range of activities was on offer at the home.

When complaints were received, the provider responded in a timely manner.

Is the service well-led?

Aspects of the service were not well led.

Staff morale was low.

There had been significant changes at management level and staff did not always feel they were kept informed of these changes.

QA audits to monitor the quality of the service were minimal and therefore were not effective in driving improvements to the service.

Requires Improvement 

Abbeyfield - Richard Cusden

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 18 and 22 February 2016. The first day of the inspection was unannounced; the provider knew we would be returning on the second day.

This inspection was undertaken by one inspector, an expert by experience, and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses services like this. On this inspection the specialist advisor was a qualified social worker.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We spoke with 12 people using the service, and nine staff members including the manager, deputy manager, the chef and five care workers. We looked at records including four care records, six staff records, training records, complaints and audits.

Is the service safe?

Our findings

People were not always protected from avoidable harm as not all risks were adequately mitigated against. Each of the care plans contained some risk management assessments, however we found that these were not always being completed correctly.

A falls prevention risk assessment for a person identified at high risk of falls was last completed in June 2015. Since that time, this person had suffered a number of falls and the risk assessment had not been updated.

A Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given person. We saw that the provider was not using this tool correctly. One Waterlow pressure score completed in February 2016 was not scored correctly. The provider had failed to consider the person's age when calculating the risk. We reviewed another Waterlow for a second person, which again was not scored correctly.

This showed that staff did not have clear and consistent information about people's healthcare needs and associated risks to their safety and wellbeing.

The above identified issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Environmental risk was appropriately assessed. A number of health and safety checks had been completed by the provider, both internally and by external contractors. An environmental and a COSHH risk assessment had been completed in February 2016. Current certificates for PAT, fire extinguishers inspection, fire alarm and emergency lighting and certificate of testing and a domestic electrical installation were all seen.

Weekly fire alarm checks had been completed but the manager was not aware when the last fire drill had taken place, however the fire safety log demonstrated the fire drill was last carried out on the 03/02/16.

When we asked people if they liked living at the home and if they felt safe, they responded positively.

Some of the care workers that we spoke with were not familiar with the term 'safeguarding' and what it meant. However, once we explained it, they were able to tell us what steps they would take to safeguard people from abuse. They were also able to identify potential signs of abuse. One care worker said, "We know our residents, we can tell by their body language." We saw from training records that safeguarding training had not been delivered to all of the staff.

The manager told us there were typically four staff members on the day shifts, one of those being a senior and 3 waking night staff. The manager told us they did not use a dependency tool to work out staffing levels, but since she had come into the service she was reviewing staffing levels to see if they needed amending. She told us she was keen to use a dependency tool as she considered this would help to ascertain appropriate staff levels based on people's needs.

We reviewed staffing levels at the home and looked at the rota for the period 1 February 2016 to 14 February 2016. We saw that over these 14 days, there were five shifts with three care workers on instead of the expected four, we were told the head of care was available to cover the gaps. There were always 3 care workers on at night. Care workers told us sometimes there were three of them on duty during the day and no fourth care worker was provided. They told us it was not easy to manage peoples' personal care needs when staffing levels were at this level and they felt pressured during these times. They told us that in their opinion, four care workers were needed to manage the needs of people using the service.

On the day of the visit there were four care workers on shift, but no senior care workers due to illness. There appeared to be sufficient staff on duty and we noted staff spending time chatting with people and spending some time with them.

Staff were recruited safely. Staff files contained evidence of references sought and criminal records checks. The provider kept a record of all Disclosure and Barring Service (DBS) numbers for staff. The Disclosure and Barring Service provides criminal record checks and barring functions to help employers make safer recruitment decisions.

We reviewed medicine administration records (MAR) for two people. These were completed correctly and in line with prescriptions. Medicines were stored correctly, either in the fridge or in the medicine cabinet. Medicines in the cabinet were stored in fixed pigeon holes for each person containing 'as required' (PRN) medicines, a medicines trolley with blister packs for each person or general PRN medicines in shelving. We reviewed the medicines policy which looked robust.

We discussed the medicines procedure with the deputy manager who was responsible for overseeing the prescribing and administration of medicines. Only trained care workers were responsible for administering medicines. Care workers administered medicines for all the people, but those that were able to open the disposable medicine pots from the blister packs were encouraged to do so.

Is the service effective?

Our findings

We requested records for all the training that had been delivered to the care workers. When we compared the training that had been delivered against the expectations of the provider with regards to the topics that were deemed essential we found gaps.

Dementia awareness was essential for all staff according to the provider and was to be renewed every two years. We found that not all staff had been provided with this training and some care workers with this training had received it over two years ago. None of the staff had received training in MCA and DoLS or managing behaviour that challenged.

There were other gaps in training, including care planning, nutrition and wellbeing, equality and diversity and dignity and respect.

Therefore staff were not always equipped with the skills and knowledge to enable them to meet people's needs effectively.

The above identified issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. People that we spoke with were aware if they weren't able to leave the home independently. They understood that this was for their own safety as their mobility had deteriorated. They were all comfortable with the staff's support in this area. We saw people go out to the post office during our inspection and staff told us they often asked people to come with them if they went to the local shops. One person said they were not able to walk as independently to the local cafe as before but added that "Staff are very happy to take me out" whenever she liked.

Care workers that we spoke with were not familiar with the MCA or DoLS and told us they had not received any training on this. One care worker did say that they helped people to make decisions through engagement and rapport building. They said, "I've not had training in mental capacity, I'd love to learn more about it" and "Nothing is ever forced on them (people using the service)."

Care workers were not always clear about which people were not restricted from leaving and were able to

go out of the building by themselves. They were not certain which people were subject to DoLS and who was not.

We reviewed the DoLS applications that were in place for people using the service. 14 applications had been submitted for people that had their liberty restricted in some way, five of these had been accepted and one rejected because it was felt the person had the capacity to make decisions. The provider was still awaiting a decision on the remaining applications. We found that one person's application was out of date and had expired in October 2015.

There was evidence that advocates had been consulted and were involved in some of the DoLS applications. Independent Mental Capacity Advocates (IMCA) are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

We saw evidence that people were referred to healthcare professionals in relation to their health needs. A record of visits by professionals, for example GPs, district nurses, community psychiatric nurses, and social workers were kept. Care workers told us, "All the residents are registered with one GP" and "The GP does regular health and medicines reviews."

People were overall satisfied with the food provided although one person said "The food is much better here at weekends."

Some care workers expressed concerns with the length of time agency staff had been employed in the kitchen. We spoke with the registered manager about this and she said this was one of her priorities over the next few weeks and said that adverts had been placed for a permanent chef and kitchen assistant. We saw evidence during the inspection that she was setting up interviews for potential candidates for these positions.

We spoke with the agency chef during the inspection. They were aware of some requirements but not others. They were familiar with people's cultural needs within the service but not fully aware of those that required a soft diet or full fat foods or those with diabetes. The agency chef said they relied on the care workers for this information

We observed some examples of poor care during mealtimes. One person was seen taking food out from their mouth and placing it on their plate. They did this with every mouthful of food. When asked why they were doing this, they made a gesture indicating they did not like it. We asked a care worker if this was usual for this person, they told us they preferred soups. This person was then observed eating their dessert, smooth yoghurt independently. During lunch, no care workers offered this person an alternative or offered to liquidize the food as it was clear they did not like the texture of the food they were given.

We reviewed the menu for the week and saw a varied plan was in place, including fish, meat and vegetable dishes. There were two options on offer for lunch and other alternatives if people did not like any of the first two choices. The chef told us, "Everything is cooked fresh." The main meal of the day was served at lunch with a lighter supper served at 17:30 consisting of soups, burgers, sausage rolls and egg on toast. Sandwiches were served at 19:30 and a bed time drink at 21:30.

Food in the fridge was labelled with the date it had been opened and halal meat was stored separately from the rest of the meat. We saw that good quality produce was used when preparing food.

Is the service caring?

Our findings

People we spoke with told us they were happy living at the home. Some people said they liked to go out and said they were happy with the support they received from the care workers. Others said they were happy and were fond of the care staff and other people at the home. One person referred to a care worker as her "best friend" and told us they were treated "With respect and dignity." Other comments included, 'Everybody knows everybody else. It's just a way of life here, everyone just adapts to it to their way so they feel good.'

Care workers displayed a good level of knowledge about people they key worked. We asked them about people's personal history and their likes and preferences. They were able to recall details that were documented in their care plans. One care worker who was the key worker for a person told us how they worked with them and took care of their personal care needs and took them out for walks outside of the home. They explained their approach when supporting this person, who sometimes displayed behaviour that challenged. They told us they listened, used simple words and sentences and if they were not able to get the person to agree first time, they would suggest going for a cup of tea before asking again which tended to work. One care worker said, "I look at people here like my own grandparents." Another care worker told us she often took two people to the local pub as "They like their Guinness."

The conversations we overheard between staff and people were of a friendly, informal nature. It was clear that they had a good relationship and the staff knew people well. However, we saw a mixture of both good and poor examples of care.

For example, during the morning, care workers were busy delivering the activity session, doing the tea and coffee round and supporting people to the bathroom as soon as they called for assistance. They did this in a calm and controlled manner conducive to the relaxed atmosphere of the home. We saw some nice examples of some people getting involved for example, setting the table for lunch.

As people were engaging in activities throughout the morning, care workers sat with them, chatting and joining in. When one person was not able to take part in exercise activities due to limited mobility and became upset, the care worker stopped and reassured them, gently encouraging them to do what they were able to do. It was clear that the care worker was familiar with this person and knew how to reassure and comfort them effectively.

Another person who was struggling to control their coughing, was attended to by care workers promptly who offered them a glass of water which they appreciated. The care worker reassured and comforted them.

We did an observation in the lounge during the morning activity session. There were six people taking part in a sensory exercise where they identified different objects. Only two out of the six were fully engaged during the session. Two people were sleeping in their chairs and kept drifting off. We found that although the care worker spoke to people in a gentle manner, they could have engaged better with people and did not always pass the objects around so that they could have a chance to touch and feel them.

During lunch time we saw one person had fallen asleep and their face was resting on their plate of food. It was a while before a care worker noticed who then gently woke them up and wiped their face. After asking this person if they would like to continue with their meal which they declined, they took the meal away and this person was left at the table and they fell asleep again. After some time, a care worker noticed, woke them again then supported them to their room.

People's cultural and religious needs were being met by the provider. One person told us they attended church and a Christian social group weekly. We overheard a care worker talking with another person, reminding them that they attended church the previous day and talked at some length asking them how they enjoyed it. The care worker clearly knew and respected the person's faith and took an interest in it.

People were supported to maintain family relationships and were given their own space when needed. One person said their sister visited throughout the week and she was welcome any time to do so, they said staff respected this relationship. The bedrooms were individual, all smelled fresh and were clean. On three occasions, throughout the day we saw one person at the bottom of the stairs who said they did not know where their room was. On each occasion a staff member was quickly at hand to remind them. Staff offered to accompany her to her room, when she declined this was respected.

Is the service responsive?

Our findings

People were at risk of not having their needs met as care plan documentation was not always fully completed or up to date. Throughout the records there were forms that were undated and unsigned including some moving and handling and other risk assessments. The social care needs assessment for one person stated that they had vascular dementia, limited capacity and his children supported him to make decisions. However, the pre-admission needs assessments were not dated, had no details of who had been consulted when completing these assessments, contained no signatures of the person or their social worker or other professionals involved in their care.

We reviewed a care plan for a person who had been at the service since January 2016. Due to the short length of time they had been at the service, the manager told us they did not have complete care plans for this person. She said, "We have short term care plans in place, more thorough ones are done after six weeks probationary period."

The pre-admission needs assessment for this person was not complete. There were 10 areas that were assessed that corresponded to the support plans in place. However, the sections in which this person's tissue viability, mobility, fitness and falls prevention, toilet needs and promoting continence, nutrition health, sleeping and night care and personal safety and risk were assessed were incomplete. We looked at the social care needs assessment that had been completed by the social worker for this person and saw that it stated the person was at a risk of falls and had a history of falls, they were prone to wander and had previously been found lost in the community and had recently become incontinent of urine.

These areas had not been addressed in the pre-admission needs assessment for his person and therefore staff did not have all of the information required to enable them to be responsive to this person's needs and keep them safe.

We also saw instances where recommendations from health professionals were not always followed up. For example, one person had been reviewed by a heart failure nurse on 28/9/2015, 28/10/2015, 24/11/2015 and 29/12/2015. These letters stated 're-iterated the need for weight monitoring (twice weekly) and fluid balance (1.5L fluid restrictions) as well as a low fat diet'. These had not been reflected in the care plans and there was no further evidence that these recommendations were being adhered to by the provider.

People using the service, especially those with capacity to understand decisions related to their care did not have care plans that were clear about the expected outcomes and did not incorporate goal monitoring. This would enable clearer evaluation. Care plans were evaluated monthly but in many examples we saw that care workers had written 'no change', it was therefore difficult to gain an accurate picture of people's wellbeing on a month by month basis. For example, one person had three falls since July 2015. We looked at the monthly evaluation records for the mobility, fitness and falls prevention care plan for this person for the month of August 2015 until January 2016 which stated no change.

Another person's care plan from June 2015, communicated a desired outcome to remain a stable weight at

67kg but this person had since increased in weight, by almost 10kgs, with a corresponding increase in swollen legs and decrease in mobility. This had not been recorded in the care plan's 'evaluation and further action' section.

We saw minutes of a residents meeting that had taken place on 16/12/2015. We asked for previous minutes but these were not available for us to see. There were no action points for staff to follow up as a result of this meeting, although people had put in requests. Two people had said they would like to go out for a meal and two people said they would like to cook. There was no further evidence to demonstrate what action the provider was taking to support these people with these requests.

We found the above issues to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "There's always something to do here." Another person told us "I love music, it's very much a part of me." We talked about whether they were a dancer and they said they used to be. Another person told us a person came to the visit them a few days during the week and ran a quiz and provided singing entertainment. People were able to go out to Bingo and go to the local pub/shops with staff support if needed. Others were picked up by a minibus and went to a day centre or attended a local social group called 'Hobnobs'.

An activities co-ordinator worked part time at the service three days a week. Activities were run by the care workers on the other days. People's art work was displayed on a pin board in the living room and there was a pin board with photographs from their days out this summer in easy view for everyone. Care workers were very proud to show us people's work and were very proud of their talents.

We saw staff taking responsibility for running activities on the days of our inspection, when the activity co-ordinator was not around. They told us they had recently received specialist training in running activities from the community older people's team. One care worker said, "We had the ARCH team come in and deliver training around suitable activities. We took their suggestions on board." We saw evidence of the training in the training files we saw.

We reviewed the complaints policy and looked at a record of complaints. There had been some complaints, these had been documented, investigated and the complainant responded to. Action had also been taken in response to complaints received.

The complaints policy was on display in the hallway, although there were not any easy read copies available to support some people's understanding. We asked each person if they would know how to express any concerns and make a complaint. Everyone said they had never had any reason to complain but felt able to talk to the staff if they did. However, they were not aware of any procedure for making complaints.

Is the service well-led?

Our findings

There had been some recent safeguarding allegations at the service, one was an allegation of neglect and another of financial abuse. Although these had been reported to the local authority the provider had failed to send in a notification to the CQC as required.

The above identified issues were a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The manager said she had carried out two unannounced night visits since she had started, but these were purely for observation and to familiarise herself with the service. These visits were not recorded.

There was a lack of documentation with regards to other audits that were being carried out, including those from an area or regional manager. Some of the issues we identified with the care records were not picked up and there was a lack of feedback sought from people using the service or their relatives. The manager showed us results of a feedback survey but it was one for the whole provider across the country, rather than for the specific service we inspected.

Some of the incident and accident monitoring forms were not completed fully. The forms stated that they were to be completed two days after the accident and observations done by the home manager. These had not been completed for some falls that had taken place on 27/7/2015, 20/11/2015 and 28/1/2016.

We found the above issues to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken over in December 2014 and no notification had been submitted to the CQC notifying us of this. An application was subsequently submitted in July 2015, seven months after they had formally taken over.

Care workers told us that although they knew what whistleblowing was, they felt that the new manager had not been in post long enough to trust that their anonymity would be protected. We asked them if they wanted to share any information with us anonymously, they said they had no concerns about the welfare of the people using the service but sometimes they did not feel listened to.

We found staff morale to be low and some were disillusioned with how some aspects of the home were being managed. Some care workers felt the takeover by the new provider had not been handled well and they were not always kept informed of the changes taking place. Some of the comments included, "There have been a lot of changes, the deputy manager, the registered manager and the area manager", "We don't always get told what's going on within the company", "Morale has been low recently" and "The company don't seem to tell us anything."

Some care workers told us they felt the new manager, who had only been in post since January 2016 was

not approachable. They said, "The manager is not always approachable; she seems to be very busy a lot of the time", "It's hard to talk to her, it's been an adjustment for some of us" and "The manager is not always visible on the floor."

The manager spoke about the challenges she faced since she had started working at the service and her priorities for the upcoming months. She said there had been a number of changes that needed to be made to the systems and process in place, but she had no concerns about the care being delivered to people. She said, "The staff are providing good care, and people are happy here." She praised the staff for keeping things ticking along with the amount of changes with management they had to endure.

Since she began working at the service in January 2016, the manager had held two staff meetings. These were comprehensive in scope and covered a number of topics from shift planning, handovers, staff supervision, activities, medicines, recruitment and team work. One care worker told us, "We had two meetings; I've not seen the minutes."

Many of the concerns that care workers had were related to the differences between the old and the new management and also the way in which they were expected to complete certain tasks. One care worker said, "We have so much paperwork now, not getting as much time as we were with the residents." Another said, "It will take time for (the manager) to implement her ideas, most of us are used to the old way of doing things."

We saw evidence of medicine audits. There were monthly medicine audits being carried out going back to June 15. During this time some gaps were found in the medicines records which were followed up by the deputy manager.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1) (2) (e)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always appropriate and did not always meet service users' needs. Regulation 9 (1) (a) (b).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess or effectively mitigate the risks to the health and safety of service users in relation to care or treatment. Regulation 12 (1) (2) (a) (b).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider did not receive appropriate training as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a).