Mrs Susan Kay Hardman

Luke's Place

Inspection report

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Tel: 01582458201

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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

The inspection took place on 18 October 2017. Luke's Place is a residential care home which supports people who have a range of learning and physical disabilities. Luke's Place offers ground floor accommodation. The home supports a maxim of four people. At the time of the inspection three people were living at Luke's Place.

There was a registered manager in place. A registered manager is a person who has registered with the CQC 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.

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

Staff had an understanding of what constituted potential harm and abuse, but following these conversations with some members of staff we were not fully confident staff would always respond to safeguarding events. The registered manager and provider had not responded fully to a potential event when a person experienced harm. There had been another occasion when a person potentially experienced neglect. These situations had not been managed in a strong and open way.

Accidents and incidents records were not fully completed, detailing a course of action to try and prevent them from happening again.

People's medicines were not always being managed in a way which ensured people received their medicines in a safe way and as the prescriber had intended. The provider did not have a current building safety check from the fire service.

People had risk assessments in place with a plan for staff to follow in order to promote people's safety. The service was being supported by an appropriate number of staff on each shift.

Staff competency was not being regularly observed and monitored. Staff competency after their induction to their work was not being well evidenced. The service was not checking if staff had retained their understanding and knowledge to key areas of their work.

People were being supported to make their own decisions and had sufficient to eat and drink.

The staff were not always caring and respectful to people. The registered manager and provider were not monitoring this element of the service despite historical concerns with how staff have treated people at the home.

We found that people had person centred assessments but their reviews were not meaningful and did not involve the person. People's goals and aspirations were not promoted with practical plans in place to make them happen. The service was supporting people with some of their social needs but this needed further development, with timely action taken to ensure ideas were developed and put into action.

There was a lack of an open and transparent culture at the home which involved professionals, relatives, the people who used the service, and the community. The culture of the staff group needed further development with systems in place to monitor the culture of the home.

Quality monitoring audits were either not effective or they did not fully test the quality of the service which people were experiencing. Issues were not always responded to and there was no emphasis of developing and improving the service from these audits.

We could see that improvements had been made to the service and the registered manager told us that there was still more work to do.

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.

A safeguarding event had not been managed appropriately.

Accidents and incidents were not always being managed in a safe way.

The service was not always administering people's medicines in a safe way.

There was enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff competency checks were not robust or regularly taking place and well evidenced.

Staff lacked an understanding about DoLS.

People were supported to have sufficient to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

We identified issues with how staff interacted with people; which were not always respectful or caring.

The service was not evidencing how they always involved people in the service.

People's sensitive information was being protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People assessments lacked some details about people's needs.

People did not have meaningful reviews which involved them as much as possible.

People's goals and aspirations needed further development with realistic plans made.

People's assessments, in part were person centred.

Is the service well-led?

Requires Improvement

The service was not always well led.

The culture of the service needed further developing and monitoring.

Robust systems to monitor the quality of care were not in place.

The provider was not completing meaningful audits.

There was now a permanent registered manager in place.

Luke's Place

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 the 18 October 2017 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we viewed the information we had about the service. We also contacted the local authority contracts team and safeguarding team for their views on the service.

The manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, all three members of the care staff who were working that day and spoke with people's relatives. We were unable to communicate with the people who lived at the home, in a way that they could understand. However, we chatted to one person and completed observations throughout our time at Luke's Place.

We looked at the care records of two people who used the service. We also viewed records relating to the management of the service. These included risk assessments, three staff recruitment files, and training records.

Requires Improvement

Is the service safe?

Our findings

When we visited Luke's Place in August 2016 we found the service was safe. However, when we visited the home in October 2017 we found there were some areas where improvements were required.

We looked at people's medicines and found missing signatures in people's Medication Administration Records (MAR). People did not always have an explanation of when staff should give people their 'as required' (PRN) medicines. When people were given their PRN medicines staff did not record why on the MAR chart. On people's current MAR charts there was no 'carried forward' total to enable staff to audit medicines and therefore monitor if people had their prescribed medicines when they should have done. Some people had prescribed creams but there were no corresponding charts to state when these should have been applied.

When we completed an audit of people's medicines we found an out of date prescribed cream for one person. There were labels to state when certain products had been opened, but these were not signed by the member of staff, with a 'use by' date recorded. This is important because these products need to be used within a certain time frame once they are opened. This is to ensure the medicine is effective. The medicine audit completed by a senior member of staff, the registered manager and provider, had not identified these issues.

During our visit we asked for a general fire safety certificate relating to the building, but the provider could not produce this. We told the registered manager about this, who said they would resolve this issue.

The registered manager had a system of monitoring accidents and incidents. However, the three accidents and incidents records which had been completed did not demonstrate what action had been taken to respond to these individual events. There was no corresponding plan in place to also prevent these types of events from happening again.

These shortfalls represent a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we looked at these accidents and incidents records we identified that there had been a safeguarding event. This involved one person at the home harming another person. This should have been identified as a safeguarding event, and the local authority and we at the Care Quality Commission CQC should have been notified. An investigation with a plan of action to try and prevent it from happening again should have been completed. However, this had not happened.

We were later told about a further incident which resulted in a multi professional's, relatives, and provider meeting. The service had not completed an investigation. There was no record with clear information about how the registered manager or provider responded to this concerning event with actions they had taken to prevent it from happening again.

These shortfalls represent a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with three members of staff and asked them about their understanding of what would constitute harm and abuse. One senior member of staff struggled to answer our questions. They initially said that safeguarding is to first protect the service from being discredited by an accusation of abuse. This is not correct. The first priority should be to protect the vulnerable people at the service, by reporting the potential concerns.

With our direction staff were able to explain to us what potential abuse looked like, and what the possible signs maybe if a person was experiencing harm in some way. All three members of staff said they would report any concerns they had to the registered manager and to the local authority or the CQC if they felt the need to. When we asked one member of staff how they would report concerns to the local authority they directed us to the staff notice board, which had the local authorities safeguarding team telephone number on it.

During our visit we looked at a sample of two people's assessments. We found that the registered manager had identified the risks which people faced with a plan of action to try and mitigate these risks. Although, one person's risk assessment did not fully explore one of the risks which they faced each day. One person was at risk of choking; their risk assessment identified the different ways this person could present if they started to choke. However, their plan stated that certain foods should not be given to this person, but it did not list what these foods were. We asked two members of staff what these foods are, and they did not know. We advised the registered manager about this who told us that they would address this issue.

There were various safety checks taking place at the service. The fire equipment was being tested on a regular basis. Electrical items were being tested on a yearly basis. The service was testing for the bacterium Legionella. This can grow in water supplies and cause people to become unwell. The home's minibus was being checked on a weekly basis to ensure it was safe to use.

When we entered the kitchen in the afternoon we found the cupboard containing cleaning products was on the ground and was not locked. There was a key in the lock and it was open. Due to the ratio of staff and people at the home it would be unlikely if a person was in the kitchen alone, but this was not a safe way to store these products. One person had fallen out of the home's minibus last year. There was no plan or training in place to guide staff how they should support people's safety, when transporting people in and out of the home's minibus.

The registered manager told us that the local authority tested if people's electrical wheelchairs were safe. Two people at the home used electrical wheelchairs to mobilise. One person had three of these wheelchairs. However, the manager did not have any evidence that these safety checks were taking place. We spoke with the registered manager about this who said they would resolve this issue.

The service had an emergency contingency plan in place, if there were event(s) which prevented the service from running and put people at risk. This plan contained some practical information about what to do in the event of certain emergencies, for example who to contact and on what telephone number if there was a utility power failure. However, there was no plan of action if there was a sudden reduction of staff.

We looked at the staff recruitment checks which were taking place. We looked at a sample of three staff recruitment checks. All these members of staff had Disclosure and Baring Service (DBS) completed checks. They also had two references each, often their last employer and someone who had known them for a long

time. These members of staff had full employment histories. However, their application forms only stated to evidence their last 20 years of employment. By default all three members of staff we looked at had given their full employment histories either by an attached CV or because of their age. The provider should be ensuring they are obtaining a full employment history for the staff they employ. The staff recruitment records also did not contain evidence of their identities. This is needed when DBS checks are completed, but the service should retain copies of these as an additional safety check, and they were not doing this.

We found that there were enough staff to support people at the home. People received one to one support during the day and there were two members of staff at the home at night. We looked at a sample of the last four weeks rotas which confirmed this staffing level. We observed during our visit that staff were present and responded to people's needs in a timely way.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in August 2016 we found that the service was effective in meeting people's needs. However, at this inspection in October 2017 we found that there were areas which required improvements to be made.

Staff competency was not being effectively monitored. With the exception of supervisions the registered manager was not regularly observing staff practice and evidencing these observations. There had been historical concerns raised about the culture of the service and how staff interacted with people. Robust staff competency checks would be a way of identifying and addressing any issues like this. We spoke with the manager about this who told us their plans to introduce staff observations later this year.

The manager showed us the competency checks which they completed to monitor if staff were competent to start working alone after their inductions. These records showed that a senior member of staff had signed and ticked a box to say individual members of staff were competent in a series of key skills. However, these records did not evidence how they made this conclusion. The registered manager said staff would be asked various questions and their practice would be observed, but these records did not fully demonstrate this took place.

We asked staff how they supported people whose behaviour could challenge other people. From what staff told us and after hearing a member of staff speak with a person in an inappropriate way, we concluded that the communication skills of some members of staff were not effective.

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 so that they can 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.

When we spoke with staff about the MCA they had a good understanding about how to promote and encourage people to make their own choices with their daily living needs. Two members of staff could explain to us what mental capacity meant and how this was dependent on specific decisions. However, all three members of staff demonstrated to us that they did not understand when a DoLS was applied. Two members of staff were not aware one person at the home was placed under a DoLS by the local authority and what this meant in practice. The registered manager showed us records where they regularly checked

staff's knowledge in this area, but we found these checks were not consistently effective.

Staff received training in safeguarding, health and safety, fire awareness, epilepsy, learning disability awareness, and managing challenging behaviour. Training was a combination of on line and class room training. The registered manager explained that the pass rate for on line training was 70%. If a member of staff did not pass they said that they would support the member of staff to pass the training. We noted that one member of staff had passed the online training for DoLS but when the registered manager asked them questions they could not answer them. The registered manager was regularly testing staff's understanding of MCA and DoLS. However, they were not monitoring other important areas of staff's knowledge. The purpose of this would be to ensure staff members had understood and retained the training they had received and to check the training was effective.

People at Luke's place were supported to have enough to eat and drink. We looked at the food menu. There was a variety of choices for breakfast and for lunch in these menus'. There was one choice for people's evening meals. A member of staff and the registered manager told us that people at the home had a meeting where they decided what would be in the four weekly menus, choosing from a combination of photos of certain meals.

We asked a senior member of staff if people did not want the chosen evening meal on the day, what happened. They told us they would offer people choices from the freezer or a 'jacket potato'. They told us that one person really enjoyed one particular meal, we asked this member of staff, what happened if this person asked for this meal. They initially said that they could not have it, and then they said that staff would make it for them. When we asked another member of staff what happened in this situation, they said a frozen meal would be offered as an alternative.

During our visit we observed one person being supported to eat their breakfast. We saw this was at the person's own pace, this member of staff, talked to this person throughout the process, and ensured they had swallowed their food, until another mouthful was offered. We also saw this member of staff asked the person what they wanted to eat and drink for breakfast, and this member of staff made it for them.

One person had a condition which effected the digestion of their food. There was clear guidance for staff to follow about what types of food it was safe for this person to eat. The staff we spoke with directed us to this guidance. We also noted that the service had involved the dietician to help manage this person's condition. However, this person was also at risk of choking. There was a lack of guidance for staff to follow to manage this risk. From looking at this person's food diary it was not clear if, the current guidance that was in place, had been followed.

During our inspection we looked at people's access to healthcare services. We discovered that a person had not attended a health appointment because the service had forgotten about it. We found out that the service re-arranged another appointment which took place. We noted in people's records that the service had made appointments for people to see a health professional when they were unwell. It was also recorded when staff had supported a person to make routine specialist health appointments. However, information recorded regarding appointments in people's care records was often not accurate and up to date.

Requires Improvement

Is the service caring?

Our findings

We visited Luke's place in August 2016 and found that the service needed to make improvements to ensure it was a caring service. At this inspection in October 2017 we found that improvements were still required.

At previous inspections we found there were issues with how staff approached people, how they spoke with them, and treated them. At this inspection we saw that staff spoke with people at times in a polite and friendly way. However, we also observed a situation which was not caring or kind. We observed one member of staff talking with one person about the support they were going to be providing them with later that day. They made reference to this person's continence needs. This was expressed in a derogatory, disrespectful, and condescending way. When we spoke with three members of staff one member of staff made reference to being "Stern" with people who expressed behaviour which challenged other people. We asked them what they meant by this, they said, "I look at them in the eyes at their level and I tell them how it is." We later heard this member of staff talking with a person. It did sound stern and unkind. We spoke with the registered manager about this. We both concluded that this particular member of staff did not intentionally mean to be unkind, but they lacked the skills to communicate with people in a kind, respectful, and polite way.

We also spoke with another member of staff and asked them how they managed situations when people who can express behaviour which others could find challenging. They said, "Sometimes I can be rude and terse with them, but I always apologise." Again, this raised questions about the professionalism of staff and their skills to manage difficult situations. We advised the registered manager about this.

The registered manager was not always evidencing how they involved people in their care. The registered manager and staff explained how they involved people in choosing the evening food menu, but this was not evidenced. Nor were discussions around people's views about the service in general. There was no information about the service which promoted advocacy services.

When we looked at people's care records we could see that the registered manager had prompted staff how to promote people's dignity and privacy when they supported people with their personal care needs. The staff we spoke with told us how they did this, such as shutting doors, and giving people private times during this support. Two members of staff told us they respected one person's decision to be alone, when they wanted to do this. However, we noted guidance in the kitchen about how to support one person who had a bowel complaint. This was placed on the wall next to the food notice board. This should have been placed in a discreet place for staff to refer to when preparing this person's food.

We looked at people's care records and we found the information about the people the service supported was expressed in a respectful way. However, there were some times in people's daily notes that the use of language in this context could be improved upon. At times staff wrote about people's continence needs in ways which was not respectful and treated the person as an adult for example, "Wet changed him."

These shortfalls represent a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited the service we found that staff had protected people's confidential information. People's care records were locked in a filing cabinet. People's daily notes were kept in their rooms but filed in a discreet way. However, one person's relative told us that they had found people's care records left in the kitchen, "For anyone to see."

People's records gave guidance to staff about how to encourage people's independence. The staff we spoke with told us how they promoted people's independence with daily tasks such as people's personal care needs and some elements of people's domestic routines.

Requires Improvement

Is the service responsive?

Our findings

We visited Luke's Place in October 2017 and found that improvements were required to ensure the service was always responsive to people's needs.

During our visit we looked at two people's records and we could see that the registered manager had produced assessments and care records which were person centred. Both people's records contained detailed information about how each person wanted to receive support from staff on a daily basis. These people's care plans contained step by step guidance for staff to follow about how to meet these people's daily needs.

People's likes, dislikes, and their interests were explored in their assessments. However, there was limited reference to what people's goals and aspirations were. When some goals were identified there was no practical plan to how these were going to be realised and fulfilled. People had regular reviews where their key worker would consider what has been working well for the person and consider elements of the person's care and support which could be improved upon. However people's goals were not being reviewed to see if the person was in fact achieving this goal or if further support was needed. For example, one person's assessment had identified they wanted to plan a holiday last summer. There was no action taken regarding this goal. It was not revisited at this person's reviews. The staff we spoke with were not aware of this goal. This person was interested in a particular style of dancing. Although this had been identified last year as something they wanted to go and watch, nothing had happened. It was not explored at their review; there was no reference to this person changing their mind about this. We asked a member of staff if they thought this person would like to go to out and see this type of dancing performed, they said, "Oh they would."

When we looked at people's assessments we could see the registered manager had considered people's mental health and what could distress some people. They had also considered people's behaviour which could challenge other people. However, all people faced communication difficulties. The assessments did not include signs for staff about how to identify if a person was low in mood, if they are distressed, or the triggers to spark behaviour which may challenge other people.

When we looked at people's records we saw examples of person centred care. Two people had daily exercise plans which staff completed after they had supported these people with these exercises. We also saw recorded in people's daily notes examples of staff responding to what a person had requested they wanted to do that day. However, there were times when people's care records were not up to date and reflected their needs. One person's care record stated they were taking eight medicines, but their MAR chart listed ten. Another person's record listed the medical appointments they had attended that year. We cross referenced this to the 'appointments book' and found that according to this record this person had in fact attended more health appointments, than their care record showed. The registered manager said that one person was receiving support from a particular health professional; this was not recorded in their care records.

We saw evidence that people were going out into the community and the registered manager had arranged some social activities outside of the home. The local authority had funded and arranged for some people to attend day services on a regular basis during the week. The staff we spoke with told us about a day trip the three people who lived at Luke's Place went on recently. However, there was a lack of future planned activities in and outside the home. Some staff talked about some ideas of social outings but there was a lack of action. When we spoke with staff and asked them if they felt the service supported people's interests and maximised social opportunities for people, they presented as hesitant and often found it difficult to answer this question.

During our visit we observed that two people had gone out for the day to attend day services organised by social services. We saw one member of staff engaging with one person with a word game during their breakfast. Later this person sat watching TV programmes. They were unable to communicate with us in a way we could understand. They appeared to engage with the programmes they were watching. Although a member of staff sat with them, there was limited interaction. We later saw the provider come and sat with them, who chatted to them at times and later, read them a children's story.

Another person enjoyed watching programmes on their electronic device, a Tablet. We saw them starting to watch one of their programmes and they were very excited and animated about this. However, the Tablet lost power in five minutes. The member of staff said, "We keep meaning to get that fixed, he gets really disappointed if he can't use it." Staff had known this piece of equipment was faulty, but they had not, tried to solve the problem.

In conclusion, we found that the service had made improvements in this area from the last inspection, but there were still areas in relation to how the service provided person centred care to people at the home, which required improvements to be made.

The registered manager had created a complaints process to follow when complaints were raised. We looked at some issues which a relative had raised. We saw that the registered manager had treated these as complaints, investigated, and took action to try and resolve the particular issues which were raised. We noted that the number of complaints by professionals and relatives had significantly reduced this year compared to last year.

Requires Improvement

Is the service well-led?

Our findings

When we visited Luke's place in October 2017 and considering Luke's Place's inspection history, we could see that improvements in how the service was being managed had taken place. However, improvements were still required for the service to become a 'Good' service.

The culture of the service was not being robustly monitored or considered by the registered manager or by the provider. There had been historical concerns about how staff interacted with people at the home. The registered manager had identified what good practice looked like in people's care assessments, but they were not monitoring how staff treated people. There was no training specifically given to address this issue. We still found some issues with how staff treated people. We raised this with the registered manager, who said that they have had to do a lot of work to improve the service, and they would now be looking at this particular issue.

When we spoke with people's relatives and professionals we formed the conclusion that the service needed to make improvements to become an 'open service' in terms of how the provider, and the registered manager, responded to negative feedback. The registered manager had improved how the service responded to complaints. However, how the service responded to accidents, incidents, and concerns did not show transparency and a willingness to learn and build relationships with professionals and relatives.

There were limited links with the local community and there were no plans in place to develop this area. The registered manager told us how the service's hydrotherapy pool was used by some people who lived at other services nearby. However, this had no real impact on the people who lived at Luke's Place.

During our visit we found that there were audits taking place to assess the quality of the service. However, these were not always effective. People's care assessments and care plans were being audited by the registered manager but we found issues with missing information relating to how people's needs should be being managed. The service was not fully exploring people's goals and aspirations. People's reviews were not being checked to ensure they involved the person and if they were meeting people's needs in a meaningful way. The administration of people's medicines was being audited but it was not always clear from looking at these records if action had been taken, when issues had been identified. The medicine audits were also not always effective as we had identified issues with the administration of people's medicines, which the audits had not identified.

The provider was also completing some quality monitoring checks. However, these were limited and did not fully test the quality of the service. We saw the provider was completing some night visits to monitor the practice of the night staff. On one record it stated that staff were watching TV when they visited. This was not good practice and their report did not identify this as an issue. The provider reports did not show if they actually spoke with staff to regularly check their understanding of key areas to their work. The provider did not look at people's care records to see if people's needs were fully being met. Despite historical issues, the provider was not testing key areas of the service for example, if people's social needs were being fulfilled.

These shortfalls represent a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of the events they must notify us about by law. However, a safeguarding event was identified when we reviewed the accidents and incident records, which had not been identified by the registered manager and the appropriate action followed. We were also aware of another event which the local authority was involved with, and we were not formally notified of this event.

The above concerns constituted a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4)

There was a registered manager in place who had been originally appointed on a short term contract to support the service to make improvements. The provider had made the decision to make the registered manager permanent in order to continue the improvements being made to the service. Considering the service's inspection history we found this was a positive step forward.

The staff we spoke with all spoke positively about the registered manager. They said that the found the registered manager approachable and they felt that they were making positive changes to the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Registration Regulation 18 Notification of other incidents. The provider had failed to notify the CQC about some safeguarding events. Regulation 18 (2) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and Respect. The provider had not ensured that appropriate action to ensure people are always treated with dignity and respect. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks.

Regulation 12 (1) and (2) (b) (d) (g).

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 Regulation 13 HSCA 2008 (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment. The provider had not ensured that appropriate action was taken when safeguarding events took place. Regulation 13 (1) and (2) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider had failed to have effective systems and processes in place to monitor and improve the safety of the service provided and to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This also included the management of the service. Regulation 17 (1) and (2) (a) (b)