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Lime Tree House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Lime Tree House Residential Home is a residential care home providing personal care to 29 older people at the time of the inspection, some of whom were living with dementia. The service can support up to 30 people.

Lime Tree House Residential Care Home accommodates people in one adapted building.

People's experience of using this service and what we found
People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The quality assurance framework was not always effective and had not supported staff to identify and address areas needing improvement. Care plans were not always clearly written and did not always include enough information for staff to support people safely and consistently. Care records were not always completed consistently to enable oversight of whether a person's behaviour that challenged was increasing or decreasing. Feedback from people and stakeholders was not used to improve the service in a timely way.

Care plans varied in personalisation. This had been recognised by the registered manager who was in the process of reviewing and rewriting people's care plans to make them more person-centred.

People told us they felt safe. There were positive relationships between people and staff and we saw them laughing and joking together. People were treated with kindness and care. One person's relative said, "I am just extremely happy with it, it is a home from home."

Staff supported and encouraged people to be independent where they were able. People's needs were assessed before they moved into the home and their hobbies, interests and life stories were included in their care plans.

People were supported to eat and drink and make choices about their meals. People with specific needs around eating and drinking were supported safely.

There were enough staff available to meet people's needs. Staff were supported with training and supervision. Staff told us they felt supported by the registered manager.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (16 June 2017)

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified two breaches of regulation in relation to people's consent and the governance of the service. The provider had failed to ensure that people were supported in line with the principles of the Mental Capacity Act 2005. The provider had failed to ensure that systems to assess, monitor and improve the quality and safety of the service were sufficiently robust.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Lime Tree House Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Lime Tree Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care provided. We spoke with six members of staff including the registered manager, the general manager, the deputy manager, senior care workers and care workers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with two health and social care professionals.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same.

This meant people were safe and protected from avoidable harm.

Staffing and recruitment

● Safe recruitment checks been completed before people started work at the home, such as references and disclosure and barring service (DBS) checks. DBS checks help employers make safer recruitment decisions.
● There were enough staff available to meet people's needs. One person said, "The staff are attentive, they are there when we need them. If I wanted something, they'd help straight away." Call bells were answered quickly, and we saw that staff had time to chat and spend time with people. One person's relative said, "There is always enough staff, you get to know them. They always chat to me. It's like one big family."

Learning lessons when things go wrong

● When things went wrong, such as an accident or an incident, staff took action to prevent it happening again. For example, one person had had a number of falls, staff had referred to the falls prevention team for support.

Assessing risk, safety monitoring and management

● Staff knew people well and managed risks safely. Risks about people's skin and the development of pressure sores was assessed. Risks around moving the person and the risk to their skin had been considered, and methods such as using slide sheets and airflow mattresses had been considered to reduce the risk. When people had wounds there were specific care plans in place detailing the support from district nurses, any equipment or medicines to support healing and how to identify infection.
● Risks around the safe moving and handling of people had been assessed and staff knew how to support people. For example, the type of equipment needed to support the person and how many staff were needed to support them to move safely. Staff had training in the moving and handling of people. Their competency to support people to use a hoist was assessed.
● There were plans in case of an emergency. Personal emergency evacuation plans detailed the support people would require evacuating the building, in the event of an emergency.
● Risks about the environment and maintenance of the building had been considered. There were regular maintenance checks and tests of fire equipment. Safety checks had been completed as required for gas and electricity.

Systems and processes to safeguard people from the risk of abuse

● People felt safe. One person said, "You know that you are safe here." Another person's relative said, "I have no worries at all, as she is so well cared for. It's lovely not to have to worry about my [relative]."
● Staff understood how to raise safeguarding concerns and types of abuse. Information was available around the home about how to contact the local authority and raise concerns through whistleblowing.
● Safeguarding concerns had been reported to the local authority as needed.

Using medicines safely

● Medicines were managed safely. We observed part of a medicines round and saw staff checking medicines against the medication administration record (MAR) before giving people their medicines. Staff observed safe hygiene practices and wore tabards to show people and staff that they should not be disturbed.
● Staff were trained in giving medicines. Their competency to do so was checked, this included what to do if people refused their medicines, if medicine was given to the wrong person and how to dispose of medicines.
● Staff knew how people preferred to take their medicines and provided them in the way people preferred. One person was often sleepy, and staff had consulted with the person's GP about when they could take their medicines safely. This meant that the person could take their medicines safely, when they were able.
● Medicines were stored safely. The temperature of medicine storage was regularly checked to ensure that medicines remained effective. Medicines which required additional security measures were kept accordingly.
● Some people were prescribed 'as required' (PRN) medicines. These are medicines that only need to be taken when needed, for example pain relief. Details of the dose given, the reason and result of the PRN medicine were recorded.

Preventing and controlling infection

● Infection control was well managed. The home was clean and tidy. Staff had training in infection control. Staff used personal protective equipment (PPE), such as gloves and aprons as needed. Bathrooms were well stocked with PPE.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA.

- People were not supported accordance with the MCA. Staff had received training in MCA and DoLS but did not understand how to assess people's capacity to make decisions. Staff used a tool to assess whether a person may be living with dementia, to assess people's capacity. The tool was not intended for this purpose.
- People were not supported to maximise their ability to make decisions. One person's capacity assessment included reference to their hearing impairment contributing to their lack of ability to make a particular decision. Staff had not explored other tools or methods to help the person understand the choices available to them. We spoke with the member of the management team who completed the capacity assessments. They lacked understanding of the MCA and how to appropriately assess a person's capacity to make a particular decision.
- People were not supported to be part of decision making if they were considered to lack capacity. Staff had made decisions in people's best interests. A member of staff told us that when people were assessed as lacking capacity to make decisions, they would not be involved in the best interest decision process. They told us, "We would update the care plan about mental capacity. They can make small choices such as clothes or food but not bigger decisions." For example, about the use of bed rails and staff managing people's medicines.
- Staff had not always ensured that people's relatives had legal authority to make decisions on behalf of people, before allowing them to make those decisions.

The provider had not ensured they were following the principles of the Mental Capacity Act. This was a

breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had considered whether people needed to be referred for DoLS where their liberty was restricted. Referrals had been made for people who staff considered to need a DoLS but had not yet been processed by the local authority.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before they moved into the home. These include various aspects of people's care needs such as their mobility needs, preferences and information on how they liked to spend their time.
● People's needs, and risks were assessed using recognised assessment tools. For example, the risk of people being or becoming malnourished was assessed using the malnutrition universal screening tool (MUST) and people's skin integrity was assessed and monitored using a Waterlow assessment tool. This enabled staff to monitor these risks and prompt referrals for specialist advice and support when needed.

Staff support: induction, training, skills and experience

● Staff new to the service were supported with an induction. This included being shown around the home and some initial training. One member of staff told us, "It was day by day, slowly. They told me if I made mistakes and observed me." Another said, "I was introduced to residents, got to know people, their communication and capacity."
● Staff had regular supervision. One member of staff told us, "I talk about things that go well, anything I would like to discuss, any struggles, any training I'd like to suggest or attend. She gives me general feedback on my achievements and anything to improve."
● Staff received training to help them support people, such as health and safety and food hygiene. Staff had also completed dignity in care training, dementia and pressure care training to ensure they had the right skills to support people. One person told us, "I sit in on some of their training sessions. The training is to a very high standard."

Supporting people to eat and drink enough to maintain a balanced diet

● Meal times were social occasions, when people gathered to eat together and chat. Food was presented nicely and there was classical music playing.
● People were offered their choice of food and drink. One person told us, "The food is excellent. We have a choice of two main meals and two desserts, or ice cream. There are options, which is nice. I've yet to have something I don't like." Another said, "I've no complaints whatsoever. All the food is very good."
● People received the support they needed during meal times. Some people were supported to eat and drink. Staff encouraged people to eat independently, whilst monitoring them for safety.
● When people had specific needs around their diet this was understood by staff. For example, one person required pureed food and their drinks to be thickened. They were identified as being at risk of malnutrition, so their diet was fortified by adding additional calories. The person's weight was checked every two weeks and their care plan guided staff to refer to the GP if there was weight change over a certain period.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to access health care support when needed. One person's relative told us about when their relative had been unwell. They said, "She has had some not so well times and they worked hard, cared for her and she has picked herself up far quicker than if she'd stayed in hospital."
● Staff worked with other professionals to ensure people received the right support. One health and social care professional told us, "We are called out appropriately to see residents who are unwell, and our plans are followed appropriately with appropriate escalation if needed."
● Specific plans were in place for people's health conditions. For example, one person had diabetes. Their care plan assisted staff to understanding this condition, the monitoring they needed and what to do if they were unwell. Risks of additional health complications, such as with eyesight and feet had been considered.
● People's oral health care was planned for and supported. Records showed that people had regular involvement with health care professionals, such as GPs, community nurses and chiropodists as needed.

Adapting service, design, decoration to meet people's needs

● Signs around the home helped people to move around it independently. For example, there were pictorial signs of bathroom doors.
● People's bedrooms were personalised with their belongings, and when people wished, they could bring in furniture to further personalise their spaces.
● Equipment was available to assist people to move around the home. Specific equipment such as hoists were available and regularly checked.
● People could access the garden and spent time chatting together on a large decked area overlooking the garden.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

● People were treated with kindness and compassion. One person said, "It's fantastic, the best in Sussex. I was a bit dubious coming, but it proved me wrong. Staff are absolutely ace." Another person told us, "I'm extremely happy, and looked after very well."
● People and staff had positive relationships. For example, one person enjoyed laughing and dancing with a member of staff whilst they moved to their chair. One person told us the staff were, "Good and very kind people. They think of it as a vocation."
● People were supported emotionally. One person told us about a recent bereavement. They said, "The staff supported me wonderfully. They were marvellous. Everything was done that could be done."
● Staff looked out for any support people needed. One person's shoe fell off, so they stooped to retrieve it from under the table. A member of staff quickly offered to help get the shoe and spent time laughing and joking with the person.
● Visitors were welcomed to the home. One person told us, "I can have visitors when I want." Another person's relative said, "When I come in they are always very welcoming, we're invited for family time. I'm so glad that I found it." Another said, "I am allowed to come when I like and take her out."

Supporting people to express their views and be involved in making decisions about their care

● Staff understood the importance of people making day to day decisions about their care. One member of staff told us, "Anything we are going to help people with we ask permission. We give them choices, for personal care, meals, activities, when to get up and when to go to bed, what to watch on television. We don't decide for them, we given them the options for them to choose. We tell them what is available, and they make the decision. Some residents can't decide at all, we will still let them know who we are, what we are about to do, so they know what is happening." We saw staff offering people choices in what they wanted to do, or whether they wanted anything to eat or drink.
● There were regular meetings with people who lived at the home. One person told us. "We have meeting where residents and staff meet together. We talk about what we'd like and wouldn't like."
● One person's relative told us, "Mum feels she can go and speak to them. She is able to go up to staff if she feels someone needs attention." And "There is great respect for individual's choice."

Respecting and promoting people's privacy, dignity and independence

● People's privacy was respected. Staff knocked on people's doors and waited for their consent to enter.
● People's independence was promoted. For example, staff offered to support people with cutting their meat but respected their independence when this was refused. Another person's relative told us about how staff had helped their relative regain independence. They said, "She wasn't good on her feet but is now back using a zimmer frame. They helped her get back to where she was."
● People were encouraged to maintain their independence. Staff prompted a person to use their walker independently, staying close to them so they felt supported. Once the person had steadied them, the member of staff praised their independence.
● Staff understood how to protect people's confidentiality and keep information safely and securely.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● The general manager had recognised that not all care plans were written in a personalised way, with the focus on tasks to be carried out by staff. The care plans which had been written recently were written in a more person-centred way. For example, one included the person's preferences and how they liked to spend their time. It included the person's interests and that they liked to help out around the home. There was a plan in place to review and rewrite the remainder of the care plans. We considered this to have a low impact on people as staff knew people and their preferences well. One member of staff told us, "One person prefers to put their arm in their t-shirt first, another prefers to put their head in first. It's important to them that we get it right."
● Staff tailored their support to people. One person's relative told us about what could make their relative feel anxious. They said, "Staff know that. They have been able to help her not to become so anxious."
● People's religious and cultural needs had been considered. For example, one person was regularly visited by a member of their religious group.
● One person's relative said, "There is an individual quality of care, they notice the differences. They are aware to particular needs and discuss those with the individual."
● Some people, and their relatives, had completed life story books about their childhoods, backgrounds, hobbies and interests.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were considered in their care plans. For example, one person was registered blind and their care plan explained their type of sight loss and that staff should stand to the side. Another person used hearing aids. Their communication plan explained that they could still struggle to hear so guided staff to be patient and communicate slowly and clearly. We saw staff communicating with people in line with these plans.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

● Activities were available to people. One person said, "There is always something going on." One person's relative told us, "They try their best with the entertainment, for example, one guy does a music afternoon. She loves that and remembers him being very positive. A guy comes in and dances with people. That is important to mum. They do exercises and quizzes, they make an effort to make them active and participate."
● Staff spent time with people and encouraged dancing, singing and conversations. We saw people enjoying spending time with staff discussing their families and childhoods. One person told us they enjoyed conversing with one member of staff in French.
● People were supported to access the local cinema monthly for showings of old films such as Showboat. People had also enjoyed a trip to a local farm to see the animals.
● People spent time socialising together. We saw a group of people sat out on the patio enjoying the sunshine and chatting.
● People's religious needs were considered. One person told us how important religion was to them, and that their relatives went to church with them.

Improving care quality in response to complaints or concerns

● Complaints were managed effectively and responded to in a timely way. Records showed that complaints were investigated and taken seriously. Where necessary, lessons were learnt. For example, one person complained about wine going missing. As a result, the registered manager reviewed the security of the storage arrangements for people's wine and resolved the issue to the satisfaction of the person.
● People knew how to raise concerns and felt confident to do so. One person told us, "Any issues, any time, I can go down to the office and they will fix it up." Another person said, "I've never made a complaint. I'm sure they would listen if I did. First of all, I'd go to [registered manager], if not I'd go to the owner. We get on ever so well."
● People's relatives also felt confident to raise any issues. One person's relative said, "If anything worried me I'd see [registered manager]. I know that she would want to know." Another said, "There is nothing that I've felt hasn't been resolved."

End of life care and support

● End of life care had been considered and discussed with people, and those important to them. This included liaising with other health care professionals as needed and to discuss pain management with the GP. Some staff had training on end of life care.
● People received dignified and personal care at the end of their lives. One person was receiving end of life care at the time of the inspection. They had a plan in place which included their preference on where they would like to be cared for.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Quality assurance checks had not identified and addressed all areas for improvement identified during the inspection. There was a care plan audit completed regularly. However, this did not give guidance about what should be checked and how thoroughly. Care plans contained wording which was not clear, and the level of detail in care plans were not always enough to guide staff to support the person effectively and consistently. For example, one person's care plan advised that deviating from their normal routine would cause them anxiety. However, there was no information given about what the person's normal routine was. This meant there was a potential risk of the person receiving inconsistent support from staff.
● Care plan audits had not recognised that staff were not supporting people in line with the MCA and that irrelevant tools were being used to make decisions about people capacity.
● Care records were not consistently or correctly completed. For example, one person had a behaviour chart to record and monitor any behavioural incidents. Whilst the chart had been used on some occasions, we found two incidents described in the person's keyworkers notes which had not been captured in the behaviour chart. This meant that monitoring of any themes and trends affecting the person's behaviour would not be complete.
● Whilst staff knew people well and managed risks appropriately, records did not always accurately reflect risks to people. For example, one person could present with behaviour that challenged. Their care plan lacked information about what could cause this behaviour and how staff should respond to help reassure the person. This meant there was a potential risk that the person would receive inconsistent care which could increase their behaviour.
● It was not always clear the action that had been taken to reduce ongoing risks. The group manager showed us a root cause analysis form which included more prompts for staff to consider, but these were not consistently completed for accidents and incidents in the home. Appropriate action had been taken by staff, such as referring to the falls prevention team when a person experienced a number of falls. However, this action was not always clear and easily available. The management team advised us they would be using the root cause analysis form to record this information in the future.

● Surveys were not used to change and improve practice in a timely way. People's views on the service had been sought through surveys. These had been completed in January 2019. However, these comments had not all been considered and used to improve the service. Comments included people not being involved in their care plans, feedback about meals, wanting more activities, and staff being in a hurry.
● People's relatives' views had been surveyed in December 2018. Some had given specific areas for improvement and these had not been addressed. For example, about meal experiences, how people were able to understand and make choices and the maintenance of hearing aids. The registered manager told us she would address and discuss the themes in the feedback at the summer party. However, this was six months after people had given their feedback.

The provider had not ensured that the quality assurance checks were sufficiently robust to identify the shortfalls we found in relation to records. This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some of the quality assurance checks did result in effective improvements. For example, the general manager visited the home to check aspects of the care provided every few months. This check included speaking to people, reviewing documents and observing practice. During one check concerns had been raised about practices around the giving and recording of medicines. Staff were given group supervision, medicine competency assessments were reviewed and medicine records were audited to address the concerns.
● There was positive feedback from people's relatives. One person's relative told us, "They have their priorities right. What really suited here was the quality of the care and a very homely atmosphere."
● Staff meetings were held regularly. These meetings gave staff the opportunity to discuss issues such as training, staffing and policies together.
● Staff told us they felt supported by the management team. One member of staff said, "I can meet with a senior, or go in to talk to [registered manager] when I need to. I feel very welcome in the office." Another member of staff told us. "[Registered manager] manages everything very well. She really cares and worries about people."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and staff team understood duty of candour. For example, complaints were responded to openly and in a timely way. One member of staff said, "If an incident happened we inform the family and tell them about safeguarding."

Working in partnership with others

● Staff and the registered manager worked in partnership with other professionals. One health and social care professional said, "[Registered manager] has always seemed to care about the residents and put their best interests first. She is organised and efficient and the care home are a pleasure to work with."
Another health and social care professional told us, "Throughout the years I have appreciated working with the team in Lime Tree. The communication from staff has always been appropriate, the information we are given when called or have attended has been comprehensive. When a staff is joining me in the visit they are well informed about the call and the details of the care the resident has. They are prompt and accurate and deliver instructions accurately."

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured they were following the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the quality assurance checks were sufficiently robust to identify the shortfalls we found in relation to records.