

Ashleigh Court Care Limited

Ashleigh Court Rest Home

Inspection report

20 Fountain Road
Edgbaston
Birmingham
West Midlands
B17 8NL

Tel: 01214201118

Date of inspection visit:
16 July 2019
17 July 2019

Date of publication:
23 August 2019

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

About the service

Ashleigh Court Rest Home is a residential care home providing personal care to 22 people aged 65 and over at the time of the inspection. The service can support up to 22 people.

The care home accommodates people over three floors which were accessed by a lift in one adapted building. It provides care to older people, some of whom are living with dementia and mental health needs.

People's experience of using this service and what we found

People were not consistently protected from the risk of abuse. The service recorded incidents and accidents however failed to effectively monitor these. Risks to people had been assessed and measures were in place to mitigate, however, this had not consistently been put into practice. People told us, and we observed there were enough staff on duty to meet the needs of people. People received their medicines as prescribed.

People were not supported by staff who had received on-going training. We received mixed feedback from people in respect of meals. People did not have a pleasant meal time experience. People were given meal choices that were not in line with their cultural and individual preferences. People's oral health care plans and diabetes care plans needed developing to ensure staff had guidance to follow. People were not supported to have maximum choice and control of their lives and staff did not 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.

People said staff were kind and caring and they had good relationships with staff. There were times, however, during our inspection we felt staff did not engage with people as much as they could have. People's dignity and privacy were compromised on occasions.

People did not consistently receive personalised care that was responsive to their needs. People told us they did not contribute to the planning and reviewing of their care. There were limited opportunities for engagement and stimulation for people daily and within their local community. People could not be confident that their wishes during their final days and following death would be understood and followed by staff.

The provider's systems for identifying, assessing and mitigating risks had not always been operated effectively. The registered manager carried out audits of the service, but these had failed to ensure that people were always safe and that their needs were being met.

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 (published March 2017). We rated Safe, Effective, Caring and

Responsive as good and the key question Well-led requiring improvement.

Why we inspected

This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvement. Please see the relevant key question in the safe, effective, caring, responsive and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashleigh Court Rest Home on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to safeguarding people from abuse and improper treatment, person-centred care and the governance of the service.

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 not always safe.

Details are in our safe findings below.

Requires Improvement ●

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 not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Ashleigh Court Rest 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

The inspection was carried out by one inspector and one assistant inspector.

Service and service type

Ashleigh Court Rest 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 the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with 11 people who used the service and three relatives about their experiences of the care provided. We spoke with 11 members of staff including the nominated individual, registered manager, deputy manager, senior care workers, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with one visiting healthcare professional. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 continued to seek clarification from the provider to validate evidence found. We looked at training data, fire safety documents and other records relating to people's care. We spoke with four relatives about their experiences of the care provided.

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 deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not consistently protected from the risk of abuse. The provider's systems and processes were not fully embedded to protect people from potential abuse and to recognise and consider when safeguarding referrals needed to be made.

- We were notified by the Local Authority of two alleged safeguarding concerns prior to our inspection. The registered manager had not notified The Care Quality Commission (CQC) as required by law. In response to our concerns the incidents were retrospectively reported to CQC.

- Whilst the registered manager had recently instructed staff to record identified bruises, there was not a system in place to ensure thorough investigations were undertaken in line with good safeguarding practices.

- There were safeguarding concerns being investigated at the time of our inspection.

- Although the staff we spoke with said they would report any concerns, some were unsure of how to report concerns to external bodies and were unsure about the whistle-blowing procedure. 'Whistle-blowing' is the term used when an employee passes on information concerning wrong doing or poor practice. In addition, not all staff were up to date with safeguarding training

- The service recorded incidents and accidents however failed to effectively monitor these. This meant that the service were unable to note trends that may be present in order to prevent comparable occurrences in the future.

People had not been protected from the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

Assessing risk, safety monitoring and management

- People told us they felt safe. One person said I do [feel safe], there's a lot of people about, I don't worry about break ins, a place like this is very secure." A relative told us, "I'm confident my relative is safe."

- People had been assessed where risks had been identified in relation to their health and well-being. These included skin integrity, moving and handling, mobility, nutrition and hydration. Risk assessments gave staff guidance which enabled them to help people to stay safe. However, staff did not always follow guidance in practice. For example, one person had been assessed as needing a soft diet and records we reviewed indicated foods which were not considered a soft diet had been given to the person. This was brought to the registered managers attention.

- We looked at other risks, such as those linked to the premises. The staff we spoke with were familiar with the fire emergency procedure at the home. We saw 'grab and go' bags were situated in the reception for the event of an emergency.

- However, the registered provider had not acted in accordance with the associated Health Safety Executive guidance for fire safety risk assessments in residential care premises. The fire safety risk assessment was last reviewed by a competent person in October 2016. The provider responded immediately during and after the inspection. They confirmed that they had scheduled a fire risk assessment to be undertaken by a competent person.

Staffing and recruitment

- People told us they felt there were enough staff. One person told us, "Yes, enough staff, they come quick enough if I pull the buzzer." A relative said, "When I visit there seems to be enough, but I'm not there all the while."
- Staff consistently told us there were not always sufficient staff deployed to meet people's needs. One staff member said, "There is not enough staff, we are too rushed." We shared this feedback with the provider.
- On the days of our inspection we observed there were enough care staff to meet people's needs and call bells were answered in a timely manner.
- There were no current staffing vacancies at the service. The provider had a tool to assess the number of staff required, based on people's support needs. We saw staffing rotas reflected this.
- Staff recruitment files included checks on their identity, character, and work history. Staff employment was subject to satisfactory disclosure and barring service (DBS) clearance.

Using medicines safely

- Senior care staff took responsibility for administering medicines and we observed they did this with patience and kindness.
- Systems to manage medicines were organised and ensured safe and timely administration of medicines to people. Staff were following safe protocols for the receipt, storage and disposal of medicines.
- Staff competency in relation to medicines was not regularly checked and was not recorded.

Preventing and controlling infection

- People were happy with the cleanliness in the service. One person told us, "My room is nice and clean." A health professional said, "Hygiene is good."
- We observed staff followed good hygiene practices. The service had an inspection by an environmental health officer in August 2018. They had awarded the kitchen a '5' star rating. This meant that the kitchen had very good hygiene standards.

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.

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

- People were not always supported to eat their meals. We observed staff placed meals in front of people without explaining what their meal was. People were not always shown the meal options on offer in a way that would help them to make a choice each day. This was not supportive of people living with dementia.
- People did not always receive meals that were in line with their cultural preferences. We observed on two occasions a person being offered a food which did not meet the person's cultural and religious needs.
- People shared mixed views about food. One person told us, "Food is delicious." However, other comments included, "Portions are too small.", "Food not served on time." and "Food is cold."
- We found mealtimes were not a positive and pleasant experience for people. Staff were task focused and missed opportunities to interact with people. We observed food was not presented well. For example, at tea time people were served a hot beef burger, cold sandwiches and a cake all on one plate.
- People told us they were not involved in the planning of meals. Whilst some records we reviewed demonstrated people had been asked for their views on the menu, there was no evidence that all people's views had been listened to and acted upon.

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.

- During our inspection we observed staff gaining consent from people before supporting them with their needs. A staff member told us, "You can't take people's rights away."
- We saw that capacity assessments were completed, when necessary, to determine what capacity people had to make decisions for themselves.
- However, one person's end of life plans recorded that they did not want to be resuscitated if they were unresponsive to immediate lifesaving treatment. We noted that although the documentation had been completed and was available in the person's care plan there had been no involvement or consultation with the person. The person's care records identified, and we were told that the person had capacity to make their own decisions. Following our inspection, we were informed that the person had been consulted with and they had expressed their wishes to be resuscitated. This meant that the person's rights had not been properly considered or protected.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Some of the staff we spoke with did not always know which people were subject to authorised DoLS. The registered provider had not worked with the staff team to make sure they understood who was legally authorised under DoLS and how best to support them with their restriction, ensuring least restrictive practices were followed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

- People were assessed prior to them moving to live at the home. The assessment document provided key information on people's physical needs and risks. However, it had not consistently taken into account people's emotional and social needs, sexual orientation and cultural and religious needs.
- There was little for people to find to enable them to engage in independent activity such as accessing objects to occupy and stimulate, this would enhance the quality of life for those people living with dementia. There were some pictorial signs on doors to denote bathrooms and toilets.

Staff support: induction, training, skills and experience

- People told us that in their opinion staff had the skills and right experience to meet their needs. A relative said, "Staff have the right skills to support [name of relative] with their dementia."
- Some staff told us they felt suitably trained and skilled to do their job. However, we found gaps in staff refresher training that had been identified as mandatory by the provider. The provider recognised this was an area that required strengthening and plans were being made to ensure staff training was up to date. We were sent an updated training matrix after the inspection which included moving and handling training.
- Care staff told us, and records showed that newly recruited staff undertook induction training when they first started to work for the service. This included the Care Certificate, which is a nationally recognised set of standards to ensure staff have the right skills, knowledge and behaviours.
- Staff we spoke with told us that they felt supported in their roles and that the management team were approachable.

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

- The service supported a number of people with behaviours that challenged. One person frequently refused to leave their room or be supported with their personal care needs. There was no evidence that staff had sought input or support from the community mental health team to better equip staff to manage those behaviours. The provider agreed to initiate contact.
- People told us they had access to healthcare professionals when required. One person said, "The doctor is called if I need them and the chiropodist is here today."
- Care plans we sampled did not contain guidance for staff to follow in relation to some health conditions such as diabetes and oral care.
- Systems were in place to ensure that people received consistent care when they transferred between services. For example, a hospital transfer form was used to support people when they were admitted into hospital.

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 deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- We saw some occasions where there were positive and caring interactions between staff and the people they were supporting. However, this was not consistent. Our observations throughout the day showed that interaction between staff and people seemed mainly task orientated, and when people required direct support with personal care, to move or when eating and drinking.
- We also carried out a SOFI [Short Observational Framework for Inspection] observation to capture and reflect the experiences of people who couldn't verbally tell us their experience of care. During the observation we saw that despite staff being present in the communal lounge there were periods of time where staff did not interact or engage with people. This lack of interaction failed to benefit people's well-being. This did not demonstrate a caring and compassionate approach to people's care.
- People spoke positively about the standard of care provided and spoke warmly about the staff who supported them. One person told us, "I like them, and they like me, they are kind to me." A relative said, "Staff are kind and nice."

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

- People told us, and records confirmed that they had not been actively encouraged to be involved in discussing or reviewing their own care on a regular basis.
- People told us they were involved in some decisions about their daily care, such as what time they got up in the morning. However, one person told us, "They [the staff] try and make decisions for me but I soon tell them." A staff member told us, "It's important to encourage people to make their own choices."

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not consistently respected and promoted. Staff told us, and we saw that privacy screens in one double occupied room were not available or being used to maintain people's dignity and privacy.
- Whilst we observed staff promoting people's independence with tasks such as allowing people to walk with their walking frame and promoting people's independence at meal times; we did not observe many opportunities for some people to take part in everyday living skills, for example, helping to set a table for lunch if they wanted.
- People were supported to maintain important relationships. One relative told us, "I can visit when I want and spend private time in [name of person] room."

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 deteriorated to requires improvement. This meant people's needs were not always met.

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

- People did not always receive personalised care that was responsive to their needs.
- People's pastoral care needs were not consistently met. The service had not made links with different faith leaders so individual visits could be arranged to enhance religious services that were provided to people in communal areas. A relative said, "My relative's religion is very important to them and they miss it now they are here."
- During our inspection we found that staff followed a routine when providing care, which was not personalised. Staff advised us that, where possible people were given choices around when they would like to get up and we saw a few more independent people in the dining room for breakfast. However, we observed, and staff described a general routine in place whereby staff were focused on tasks.
- Some staff we spoke with did not understand or recognise people's needs based on their protected equality characteristics. One staff member told us, "I'm not sure what it means for people here."
- People had access to some activities, but they were not person centred and regular.
- People told us they were bored and did not have enough to do. One person told us, "There are days I sit and do nothing." A relative said, "People sit around all day doing nothing but staring at the walls."
- During day one of the inspection an external activity person visited the home and during these times it was apparent people were stimulated and enjoyed themselves as they were observed smiling, dancing and clapping their hands to the music.
- However, on day two of the inspection people were seen to spend large amounts of time unoccupied, with televisions playing without people actively watching them or engaged in any other types of pastime. It was not evident how people's preferences, interests and hobbies had been considered.
- People were not encouraged to access and integrate with the local community with support from staff to reduce social isolation. Whilst the registered manager told us that people were supported to maintain their skills and independence, where appropriate, this was not observed during both days of our inspection.
- People and staff told us there were no regular or planned trips out. One person told us, "We never go out." There were no activities in place to support people who lived in their rooms to pursue activities they enjoyed or help to prevent social isolation.

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.

- The provider understood people's information and communication needs. These were identified, recorded and highlighted in care plans.
- However, the provider was not meeting the accessible information standards for all people they supported. There was a range of information available to people within the service, however not all of it had been adapted to support people. Particularly for those living with dementia. For example, menus providing information about the meals that were available, were written on a chalk board and were not supported with other types of communication that might aid people's understanding and choice, such as photographs and pictures.
- The registered manager told us picture cards were available. However, we did not see these being used during the inspection.

End of life care and support

- Nobody was receiving end of life care at the time of the inspection.
- However, people could not be confident that their wishes during their final days and following death would be understood and followed by staff. Some people who lived at the home had strong faith and religious needs and may have had specific end of life wishes. The service had not explored people's preferences, choices, cultural or spiritual needs in relation to their end of life care.

The lack of robust processes to ensure care was personalised and able to meet people's needs effectively demonstrated a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- People told us they knew how to complain if they wanted to. Most people told us they would speak with the manager or a member of staff if needed. One person said, "I would complain to most of them [the staff]."
- The provider displayed their complaints policy and people had the information they needed should they have cause to complain.
- Some complaints the registered manager had received had not been recorded. That meant opportunities to make required improvements and learn lessons could have been missed.

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 requires improvement. At this inspection this key question has remained the same. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for 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

- People told us they knew who the registered manager was and most felt they were approachable. One person told us, "I could talk to [name of registered manager] if I needed to."
- However, the provider failed to have effective systems in place to ensure that people received person centred care that was appropriate to their needs and were given choice and control over how they preferred to spend their days.
- People told us, and records corroborated that they were not involved with the planning and reviewing of care plans.
- There were no quality assurance systems in place to consider the impact of not adapting the premises and information to enable person-centred care to enable people to communicate effectively.
- The registered manager and provider had not identified the concerns we have found with regard to the mealtime experience and outcomes for people.
- The provider had a duty of candour policy in place and they were aware of their responsibilities to be open and transparent when things went wrong. The latest CQC inspection report rating was on display in the reception area of the service
- The registered manager and provider were receptive to feedback and proactive in making improvements.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were no systems in place to show that learning from accidents and incidents had taken place or how the information gathered had been used to prevent or reduce the likelihood of a reoccurrence.
- Systems in place to monitor people's health and well-being were not effective. We looked at care plan audits and they had not identified the shortfalls we found during the inspection. For example, we found one person's food intake was being recorded but had not been monitored.
- There were no systems in place to demonstrate the registered manager had checked staff had received refresher training they had identified as mandatory.
- There were no effective systems in place to check the competency of care staff to ensure they were equipped with the skills needed and were applying their learning into practice. For example, senior staff's medicine competencies were out of date.

- The registered provider's systems and processes were not fully embedded to protect people from potential abuse and to recognise and consider when safeguarding referrals needed to be made. We were notified by the Local Authority of two alleged safeguarding concerns prior to our inspection. The registered manager had not notified The Care Quality Commission (CQC) as required by law. In response to our concerns the incidents were retrospectively reported to CQC.
- The provider had a quality monitoring system in place to monitor health and safety. This consisted of a set of internal audits. However, these had not always been completed in line with the providers expectations. These included wheelchair and call bell alarm audits.
- People's records were not suitably maintained. Each person had a personal emergency evacuation plan (PEEP) to advise staff on how they needed to be supported in the event of a fire. However, these were not person-centred and tailored to individual needs. This was addressed following the inspection.
- Governance and oversight systems had failed to ensure the registered provider was working consistently in line with the principles of the Mental Capacity Act (2005). There were no systems in place to monitor the expiry dates for people who had approved DoLS and to review if DNAR's were still required.

The failure to operate effective systems to improve the quality and safety of the service and to keep accurate and complete records was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider offered opportunities to people to give feedback on the service they received, however, there was no evidence to show what action had been taken with the feedback received.
- Staff told us they had staff meetings, and these were used as an opportunity to share their thoughts and views whilst receiving feedback and updates about the service.
- Staff members we spoke with were complementary about the registered manager and felt involved in the running of the service. A member of staff said, "[name of registered manager] listens to our problems as well."

Continuous learning and improving care

- The service was not maximising opportunities to continuously learn and improve because monitoring systems were not used effectively.
- Both management and staff told us that new initiatives were in the progress of being implemented to develop the service. All care plans were being transferred to an electronic system.

Working in partnership with others

- The service worked closely with the local authority quality team and health professionals as they carried out regular visits 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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People did not always receive person centred care that was appropriate to their needs and reflect their personal preferences. The registered provider had failed to ensure people had access to meaningful occupation which would support their wellbeing and meet their individual needs and preferences.</p> <p>Regulation 9 (1) (3)(a)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>People were not protected by harm due to a failure to identify, report and manage safeguarding incidents.</p> <p>Regulation 13 (1) (2) (3)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not have robust systems in place to monitor the quality of the service.</p> <p>The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.</p>

