Littlebourne House Limited

Littlebourne House Residential Care Home

Inspection report

2 High Street
Littlebourne
Canterbury
Kent
CT3 1UN

Tel: 01227721527
Website: www.littlebournecarehome.co.uk

Date of inspection visit:
19 July 2018
20 July 2018

Date of publication:
30 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 July 2018 and was unannounced.

Littlebourne House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and care provided, and both were looked at during this inspection. Littlebourne House accommodates up to 64 people across two separate units, each of which have separate adapted facilities. People living at the service may be living with dementia and were able to spend time in either the main house or the King William unit. There were 60 people living at the service at the time of the inspection.

There was no registered manager in post. The previous registered manager had left in May 2018. There was a management team in place including a manager who was going to apply to be registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager and other senior care staff had left the service in May 2018. The provider had not put a plan in place to check that their roles and responsibilities were being completed by other staff. This included the management of medicines, completing care plans and assessing potential risks for new people who moved into the service. There were no care plans, risk assessments and guidance for staff for people who had moved into the service since May 2018. This put people at risk of not receiving consistently safe, effective and person centred care.

People's needs had not been consistently assessed before they moved into the service. When an assessment had been completed, this had not been put on the electronic care plan system for staff to access. People's needs were not consistently assessed using recognised tools and following current guidelines.

Audits were completed on the quality of the service but these had not been effective in identifying the shortfalls found at the inspection. When shortfalls had been identified action had not been taken to rectify the shortfalls. Medicines audits had identified shortfalls, these same shortfalls were found at the inspection, people's medicines were not being managed safely.

There were sufficient staff on duty to meet people's needs, who had been recruited safely. Staff received one to one supervision to discuss their role and development. Staff received training appropriate to their role. We observed putting their training into practice including infection control, staff wore gloves and aprons when appropriate.

Staff knew how to recognise and report abuse to keep people safe. The manager had reported safeguarding

concerns to the local authority when required. Accidents and incidents were analysed for patterns and trends, action was taken and lessons learnt to reduce the risk of them happening again.

People told us that staff were kind and caring while supporting them to be as independent as possible. We observed staff promote people's dignity and respect their decisions. People had access to a variety of activities. People's end of life wishes were recorded and staff supported people to be comfortable at the end of their lives.

People and relatives told us they knew how to complain. Any complaints received were investigated in line with the provider's policy. The complaints policy was not available in formats such as pictorial, this was an area for improvement.

People were supported to remain healthy. Staff encouraged people to be as active as possible including dancing and exercise. People were supported to eat a balanced diet and people had a choice of meals. Staff monitored people's health and when changes occurred people were referred to healthcare professionals such as the GP or dietician. Staff followed the guidance given to keep people as healthy as possible. People had access to the dentist, optician and chiropodist when required.

People were encouraged to plan their care and express their views. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to make decisions about their care and support.

People, relatives, stakeholders and staff were asked their opinions of the service. The results were analysed and the results were positive. People and staff attended regular meetings and any suggestions or concerns were addressed and resolved.

There was an open culture, we observed people going into the office and chatting with the manager and director. Staff told us they felt supported by the manager and provider and could speak to them about any concerns they may have.

The manager recognised the need to keep up to date with changes and improve their skills. The service worked with other agencies such as the local authority and clinical commissioning group.

The service was clean and odour free. People were accommodated in two units that had been adapted to meet people's needs. Checks and audits had been completed on the environment and equipment to ensure it was safe for people to use.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance.

This was the first inspection of the service after the provider change their legal entity. At this inspection three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. You can see what action we have asked the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Potential risks to people's health and welfare had not been consistently assessed and there was not always detailed guidance for staff to follow to mitigate risk.

Medicines were not always managed safely.

There were sufficient staff to meet people's needs, who had been recruited safely.

Staff knew how to recognise and keep people safe from abuse.

Accidents and incidents had been recorded and analysed for patterns and trends. Action had been taken to reduce the risk of them happening again.

The service was clean and odour free.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not consistently assessed before they moved into the service and in line with current guidance.

The buildings were adapted to meet people's needs but the signage was not always appropriate for people living with dementia.

Staff worked within the principles of the Mental Capacity Act 2005.

Staff received training appropriate to their role and received supervision and appraisal to support their development.

People were supported to eat and drink to remain healthy.

People were supported to lead a healthy life.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

People were encouraged to be as independent as possible.

People's dignity was respected.

People were supported to take part in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

New admissions did not have care plans in place to give staff guidance to meet their needs, choices and preferences.

There were activities available for people to take part in.

People's end of life wishes were recorded and people were supported at the end of their lives.

Complaints were investigated and resolved following the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits were not always effective and action had not been taken to rectify shortfalls.

There was no registered manager in post.

There was an open culture within the service. The management team had a vision for the service.

People, relatives and staff were asked their opinions on the quality of the service.

The service worked with other agencies and continued to learn to improve the service.

Littlebourne House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 19 and 20 July 2018 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information about the service the provider had sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us by law.

We looked at 19 people's care and support records, associated risk assessments and medicines records. We looked four staff recruitment files, training, supervision and staff meeting minutes. We spoke with manager, administration manager, a director, five care staff and one domestic staff.

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 observed staff interactions with people and observed care and support in communal areas. We spoke with six people who live at the service and four relatives.

This was the first inspection of the service since the provider changed legal entity in August 2017.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt the service was safe. One person told us, "I feel safe here. The staff are always around. I just press my bell and they come." A relative told us, "My (relative) is safe here. The staff are very safety conscious."

Despite these comments the service was not always safe. Potential risks to people's health and welfare had not always been consistently assessed and there was not always detailed guidance for staff to follow to mitigate risks. People who had been living at the service for a long time had detailed risk assessments and staff had detailed guidance to reduce risks and keep people safe. However, new people coming to live at the service did not have risk assessments or care plans in place.

The service used electronic care plans which staff had access to by hand held devices. We reviewed the care plans of people who had moved into the service since May 2018, there had been eight admissions. None of the eight people had a pre-admission assessment, risk assessments or care plan recorded. Some of the people had health conditions such as Parkinson's disease, diabetes and epilepsy. There was no information for staff to refer too, staff told us they had verbal handovers and spoke with people to find out their choices and preferences.

Other people had complex conditions but these had not always been assessed and staff given detailed guidance about how these conditions affected them. One person had a health condition which affected their balance, co-ordination and speech. There was no guidance for staff to recognise any deterioration in the person's condition and how to support the person.

We spoke with the manager and director, who told us that the registered manager and some senior care staff had recently left, who usually completed the care plans. There had been no system put in place to ensure that new people coming to live at the service had a care plan and risk assessments for staff to refer to.

As well as eight admissions and two more during the inspection, new staff had been employed to replace those that had left, who were still completing their induction. There was an increased risk that people would not receive consistent safe care and that people would not be kept safe.

The provider had failed to assess the risks to the health and safety of people and doing all that is reasonably practicable to mitigate any such risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff described how they supported people and how they recognised the signs of when people were unwell for example high and low blood sugars.

People and relatives told us that they received their medicines safely and when they needed them. However, medicines were not always recorded and administered safely.

When people were admitted to the service, the instructions for the administration of their medicines were handwritten. All handwritten directives should be signed by two staff to confirm that they are correct in line with current guidelines. We reviewed the medicine charts of the new admissions, all had handwritten directives that had not been signed at all or had only one signature.

Some medicines had specific procedures which should be followed with regards to their storage, recording and administration. The administration of these medicines and the recording of administration was not in line with current guidelines and best practice. The medicines needed to be recorded in a separate book and required two staff to administer and sign the book. There were five occasions when only one person had signed the book. On the day of the inspection, staff had not followed the correct procedure. Staff had signed the book to confirm the medicine had been given and this had been witnessed before it had been administered. Then only one member of staff had gone to the person with the medicine.

Some liquid medicines had a limited time when they were effective once opened. Eye drops had not been dated when they had been opened to ensure that staff knew when they stopped being effective.

The provider had failed to provide safe management of medicines. This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were prescribed medicines on a 'as and when' basis such as pain relief and medicines for anxiety. There was guidance in place for staff about when to give the medicines and how often. The temperature of the rooms and fridge where medicines were stored were recorded to monitor that they were within recommended limits to keep the medicines effective.

Checks and audits had been completed on the environment and equipment to make sure it was safe for people to use. There was a fire risk assessment in place, there was an evacuation plan in place. Staff had completed fire drills and action taken if shortfalls were identified. Fire drills had not been completed with night staff, this was an area for improvement. Each person had a personal emergency evacuation plan, to enable people to evacuate safely, some required additional information about people's communication needs. We discussed this with the manager who assured us this would be completed, we will check this at our next inspection.

Accidents and incidents had been recorded and analysed to identify any trends or patterns. Action had been taken when patterns had been identified, for example, one person was referred to their GP for review as a health condition was causing them to fall. The manager recorded the action taken and how this would prevent the incident happening again.

Staff knew how to keep people safe from abuse. They knew how to recognise signs of abuse and how to report their concerns to the manager and outside agencies if needed. They were confident that the manager would act on any concerns they may have. The manager had referred concerns to the local safeguarding authority when required and worked with them to resolve the issue.

There were sufficient staff to meet people's needs. Care staff were supported by domestic and kitchen staff who completed tasks such as bed making, this enabled care staff to concentrate on supporting people. During the inspection, call bells were answered quickly and there were staff available to support people in communal lounges.

Staff were recruited safely. Recruitment checks were completed to make sure staff were honest, trustworthy and reliable to work with vulnerable people. There was a full employment history, references and

identification. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

The service was clean and odour free. Staff followed the provider's infection control policy. Staff wore gloves and aprons when required. There were sufficient domestic staff to keep the service clean.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that staff referred them to health professionals when needed. One person told us, "The staff know how to look after me." Another person told us, "I can see the GP, dentist and optician when I need to."

Before moving to the service, people met with the provider to ensure that staff were able to meet their needs. However, recently when people had been admitted as an emergency, a comprehensive assessment had not always been completed and recorded. The provider did not have guidance in place for staff about how to assess and what action to take if people were admitted as an emergency.

When people had been assessed before moving into the service, this had been completed on paper. The assessment had not been transferred to the electronic care plans that staff had access to for guidance about people's needs and preferences.

People's needs were not always consistently assessed using recognised tools. Some people's needs were assessed in line with current guidelines from National Institute of Clinical Excellence, using recognised tools. They had an assessment for nutrition, falls and skin integrity and this was used to plan people's care. New admissions to the service did not have these assessments in place. There was a risk that people would not receive safe consistent care that met their needs.

The provider had failed to assess the risks to the health and welfare of people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Littlebourne House provides accommodation over two buildings. The buildings had been adapted to meet people's needs including wet rooms and passenger lifts. People had access to the gardens that were enclosed and safe for people walk around. The buildings had been maintained and improvements continued. The signage within the buildings was not always appropriate for people living with dementia. There were limited pictorial signs to direct people to rooms and around the service. Bedroom doors were all painted the same and brass numbers. We discussed this with the manager who told us people found their way around the service. During the inspection, people were observed finding their way around the buildings independently, but some had to helped by staff to find their way. This was an area for improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack capacity to do so for themselves. The Act requires that so 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 MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA.

People had been assessed and DoLS applications had been made when required. Some DoLS had been authorised and were recorded in people's care plans. Other DoLS had now expired, appropriate action had been taken and a new application had been made to the local authority.

Staff understood their role in ensuring people were able to make decisions. We observed people being asked where they wanted to spend their time and what they wanted to eat and drink. People's ability to make decisions about aspects of their care were recorded in their care plans. When best interest decisions had been made, these had been recorded and involved people who knew the person well.

Staff received training appropriate to their role, this was a mixture of online and face to face training when needed. Topics included challenging behaviour, diabetes and epilepsy. We observed staff putting their training into practice, people were moved safely using equipment.

Staff told us they felt supported by the management team and were able to discuss any issues or concerns with them. Staff received regular supervision and appraisals. Records showed and staff confirmed that the training and development agreed at their appraisal had been put in place.

People told us they enjoyed the food and they were given a choice. One person told us, "The food is excellent I like everything. There is lots of choice." People were supported to have a balanced diet and assisted to eat their meals when needed. We observed people being assisted at their own pace and given time to enjoy their meal. When people did not want what was on the menu they were offered alternatives. One person did not want their meal as it was a hot day, they were offered a choice including a cheese sandwich, which they enjoyed.

Staff understood the importance of people being supported to drink enough to keep them healthy. During the inspection the weather was hot, staff regularly offered drinks to people including squash and fizzy drinks and encouraged them to drink.

People were supported to lead as healthy lives as possible. During the hot weather, staff supported people to stay safe when they spent time outside in the gardens. People were encouraged to put on sun screen and sit in the shade. When people wanted to walk around the garden, they were encouraged to stop regularly and have a drink and 'take the weight off their feet'.

Staff monitored people's health and when their needs changed they were referred to healthcare professionals such as GP and dietician. Staff followed the guidance given by the health professionals, for example, people were supported to have nutritional drinks to maintain a healthy weight. People told us they saw the dentist, optician and chiropodist when they needed.

Good

Is the service caring?

Our findings

People and relatives told us the staff were kind and caring. One person told us, "The staff are kind and caring. I feel the staff respect me." A relative told us, "The staff are caring and make sure my (loved one) get what they need."

We observed people being treated with kindness and compassion. Staff spoke with people discreetly when in the communal areas, staff touched people's arms and moved closer to them. When people appeared to be anxious, staff were calm and explained what was happening to them. Staff knew about people's families and could talk to people about their children and family, this had a calming effect on people.

When staff supported people to move using the hoist in the communal lounge, they put a screen round to maintain the person's dignity. Staff explained what they were going to do and encouraged the person help when they could. We observed staff knocking on people's doors and waiting to be asked in, staff explained how they closed the curtains and doors when supporting people with their personal care. One person told us, "The staff are caring. They knock on the door before they come in."

People were supported to be as independent as possible, people were given the equipment they needed such as plate guards so they could eat their meals independently. One person told us, "They only help as much as I need. I do the rest myself." Staff were encouraged to walk using aids as much as possible. People were supported to continue their hobbies such as gardening, people spent time with the gardener and helped with the flowers when able.

People were encouraged to express their views about their care, people were involved in decisions about their care and treatment. People were asked about what they would like to do about appointments and supported to attend hospital and doctors' appointments.

People told us that there was always someone in the office to help them when they needed. We observed people discuss any concerns they had and staff supporting them to make decisions. When people had made a decision, staff supported them to arrange activities such as attending the optician.

People were supported to maintain their cultural and spiritual needs. There was a religious service each month in the lounge and people were supported to attend services in the community.

People's rooms were personalised and people could bring in small pieces of their own furniture. People had photos and pictures on the walls and their own bedding if they wanted. People were supported to maintain relationships that were important to them. People and relatives told us they could visit at any time. During the inspection relatives visited with their dogs and one relative told us how grateful they were that they were supported to bring their dog to visit their relative.

When people were unable to share their views about their care and treatment with staff and others. When people required support to do this they were supported by their families, solicitor, their care manager or an

advocate. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. People's records were stored securely.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that they knew how to complain when needed. One person told us, "If I had a problem I would talk to the manager." One relative told us, "I would speak to the manager about any issues."

People who had moved to the service since May 2018, did not have care plans in place. There was no information about people's choices and preferences for staff to refer to. Staff told us that they received a verbal handover when people moved into the service and at each change of shift. Staff told us that they would ask new people what support they would like but this would not be written down anywhere. When people were unable to express their preferences staff would not have any guidance and people would be at risk of not receiving support and care as they wanted. There was no system to monitor if people were receiving care that was person centred and met their needs.

The provider had failed to design care or treatment with a view to achieving people's preferences and ensuring their needs are met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who had lived at the service for a long time had detailed care plans that gave details of their choices and preferences including when they wanted to get up and go to bed.

The provider had a complaints policy, this was available in the main reception. The policy was not available in other formats such as easy read or pictorial to support people living with dementia to understand. We discussed this with the manager who recognised that this needed to be put in place, we will check this at the next inspection. When complaints were received, they were investigated following the policy. The action taken to resolve the issue was recorded and there was confirmation that complaints had been resolved.

People's end of life wishes were recorded when known. One person had decided when they wanted to be treated in hospital and when they wanted to be treated at the service. Staff had received end of life training and understood how to keep people comfortable. When people were becoming frail, they were referred to the GP for a plan to be agreed and medicines were prescribed so they were available when people needed them. Staff worked with the district nurses to keep people comfortable. Families had praised the staff for the support they gave their loved ones. One family wrote, "Your kindness and compassion meant a lot." Another family wrote, "We would not have wanted our (loved one) to be anywhere else."

There were a variety of activities available for people to take part in if they wanted. Activities were available each day and included music, bingo, quizzes, food tasting and a mini bus trip each Monday afternoon. People were able to choose what, if any, activities they wished to attend. The activities co-ordinators worked with people to decide what activities they would like and spent time with people on a one to one basis when people wanted. One person told us, "I go down to the quiz and listen to the musical activities."

During the inspection, we observed a variety of activities including musical entertainment, people joined in singing and dancing with staff. People also enjoyed manicures and a game of bingo in the garden.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us that they thought the service was well led. One person told us, "The home is well managed." A relative told us, "The management listens to my concerns."

There was no registered manager in post, they had left the service in May 2018. There was a manager in post who was supported by the provider and administration staff to manage the day to day running of the service. Senior members of the care team had also recently left the service, their replacements were still completing their inductions.

The registered manager and senior care staff had been responsible for the completion of care plans for new admissions and the management of medicines. The provider had not put plans in place to ensure that these responsibilities were completed by other staff. The provider had not had oversight of the admissions process and had not identified that people did not have care plans or risk assessments.

Checks and audits had been completed on areas of the service such as health and safety, infection control and medicines. The audits had identified some shortfalls but effective action had not been taken to rectify the shortfalls found. The medicines audit for May and June 2018, had identified that hand written directives had not been double signed and this continued to be a shortfall at the inspection. The audits had not been effective in identifying the shortfalls found at this inspection, such as the lack of care plans for new admissions.

People's records had not been completed consistently or accurately. There was no system in place to check that people were receiving care and support in line with their choices and preferences.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. Previously, the provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance. However, since June 2018, notifications had not been sent in a timely manner. These had been completed retrospectively.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team understood that they needed to improve and ensure their knowledge was up to date. The manager was completing a management qualification, to update their skills and understanding of their role. The management planned to attend local forums and manager's groups to keep their knowledge up to date.

The management team had a vision for the service, to strive to provide a 'Home from Home' for residents.

For them to feel welcomed, cared for, safe in their environment and empower them in their independence.

There was an open and transparent culture within the service. There was an office that was part of the communal lounge in the main house. The door was always open for people and relatives to speak to the provider or manager. During the inspection, people came into the office and were comfortable to sit down and chat to the manager or director. The manager empowered people to make decisions, during the inspection, one person was supported to decide which hospital they wanted to be treated at.

People, relatives, stakeholders and staff were asked their opinions on the quality of the service. The results of the surveys had been analysed and were positive. Feedback was being prepared for the next resident and staff meetings.

People and staff had the opportunity to attend regular meetings to express their views. People had complained that their flannels were not always named, the laundry staff took responsibility for this and people were happy at the next meeting. Staff discussed issues that had been identified and these were resolved. For example, a system was put in place for staff to ensure that people were supported to the dining room for their meals when needed.

The service supported people to be part of the community, people were supported to go to local village talks. The village school children came to the service to sing for people and the manager told us they were planning for the children to come into the service more. The service worked with other agencies including the local safeguarding team and clinical commissioning group, to ensure people received joined up care.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. This was the first inspection of the service under this legal entity.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to design care or treatment with a view to achieving people's preferences and ensuring their needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people and doing all that is reasonably practicable to mitigate any such risks. The provider had failed to provide safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each person.