Morecare Limited

Vicarage Court Nursing Home

Inspection report

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Tel: 01543685588

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 1 November 2016. This was an unannounced inspection. Our last inspection took place in July 2015 and we found some improvements were needed. At our last inspection we found there were not enough staff available and people had to wait for support. The provider was not working within the principles of The Mental Capacity Act 2005. When people were unable to consent, capacity assessments and best interest decisions were not always completed. We found some people were not offered the opportunity to participate in activities they enjoyed and the systems that were in place to monitor quality were not consistently completed. The provider sent us an action plan in November 2015 stating what action they were taking to address the concerns identified. At this inspection we found some improvements had been made, however further improvements were needed.

The service was registered to provide accommodation and nursing care for up to 39 people. At the time of our inspection, 38 people were using the service. Accommodation is on two floors and on both floors there are communal areas.

There was no registered manager in post. 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.

Risks to people were not always managed to ensure people were supported in a safe way. When people had behaviours that may challenge, there were no management plans in place for this and staff offered an inconsistent approach. Some people were not protected from potential abuse as accidents and incidents were not always investigated or reported appropriately.

The provider had not always notified us about all significant events within the home. There were some systems to monitor the quality of the service. However, we could not be sure these systems were effective to bring about improvements.

When people were unable to consent, capacity and best interest decisions had not always been completed. We found when capacity assessments had been completed they were often unclear. When people were being restricted unlawfully it was unclear which people had been referred to the local authority for assessment. There were no assessments in place to show how people were being supported in the least restricted way whilst these applications were being considered. People told us they were not involved with reviewing their care and we did not see that care was reviewed as and when required.

We could not be sure people were receiving adequate fluids as there was no guidance in place stating how much people should receive. The food that was served to people was not always warm. When people needed support from other professionals referrals had not always been made in a timely manner. People were not always supported in a kind and caring way and conversations were based on tasks. People were

not always offered the opportunity to participate in activities they enjoyed.

There were enough staff available to people and they did not have to wait. People told us staff knew them well and staff received training and an induction that helped them to support people. People's privacy and dignity was upheld. People were encouraged to be independent and make choices about their day. The provider had a system in place to ensure staff were suitable to work within the home.

People told us they were offered choices at mealtimes and they were also happy with how they received their medicines. We saw people were encouraged to remain in contact with people that mattered to them and visitors felt welcomed. People knew how to complain and when complaints had been made the provider had responded to them in line with their procedure.

Staff told us they were happy with the new manager and the changes they were making. The provider sought the opinions of people who used the service.

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

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 consistently safe.
Risks to people were not managed in a safe way. People were not protected from potential abuse as safeguarding concerns were not investigated or reported appropriately. We saw there were effective systems in place to store administer and record medicines to ensure people were protected from the risks associated to them. There were enough staff available. And the provider checked the suitability of staff before they started working within the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.
The principles of the Mental Capacity Act 2005 were not always followed. When needed capacity assessments had not always been completed and there was no evidence decisions were made in people's best interests. When people had capacity to consent to restrictions there was no evidence this had been considered. When people were being restricted unlawfully it was unclear if approvals or applications in relation to this had been made. Food served to people was not always warm. When people needed support from healthcare professionals referrals were not always made in a timely manner. Staff received an induction and training that helped them to support people. People were offered a choice of food.

Is the service caring?

Requires Improvement

The service was not consistently caring
People were not always supported in a kind and caring way and there were some limited interactions between staff and people. People were encouraged to make choices about their day and to remain independent. People's privacy was maintained and they were encouraged to keep in contact with people that mattered to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People were not involved with planning and reviewing their care. People were not always given the opportunity to participate in

activities and past times they enjoyed. People knew how to complain and when needed the provider had responded to complaints in line with their procedures. Staff knew about people's needs and preferences and shared information about people.

Is the service well-led?

Requires Improvement

The service was not consistency well led
There was no a registered manager in post. We could not be sure the provider understood their registration with us and if they were notifying us of all significant events. There were some systems in place to drive improvements within the home; however we could not be sure these were effective. The provider sought the opinions of people who used the service. Staff and relatives felt positive about the new manager and the changes they were making.

Vicarage Court Nursing 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 1 November 2016 and was unannounced. The inspection visit was carried out by two inspectors. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public. We also reviewed the current monitoring information we had received from the local authority. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this to formulate our inspection plan.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with five people who used the service, three relatives and four members of care staff. We also spoke with a registered nurse and the manager. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for five people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of Vicarage Court Nursing Home on 28 July 2015, there were not enough staff available and people had to wait for support. This was a breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection the provider had made the necessary improvements in this area; however other areas of improvement were identified.

At this inspection we found there were enough staff and people did not have to wait. One person said, "I press my buzzer and they come much quicker, if they are with someone else I wait a few minutes but not a great length". Another person told us, "The girls are always about in the lounges if you need them". We saw that staff were available for people and they did not have to wait for support. We spoke with the manager about the changes that had been made since the last inspection. They told us that there had been an increase in staffing levels and that one additional member of care staff was now provided on each shift. They also told us how they had introduced a 'casual list' of staff so these people could be called upon if regular staff went off sick. The manager had also sourced a dependency tool and was in the process of reviewing staffing levels by using this.

At this inspection we found risks to people were not managed in a safe way. For example, we looked at records for one person. This person had a care plan in place around 'diet and eating and drinking'. We saw documented, that in line with recommendations made by a speech and language therapist, the person should receive a fork mashable diet, to reduce the risk of choking. The care plan also stated the person should 'not have bread products'. We observed a staff member offered this person a diet that was not in line with these recommendations. The staff member then left the person to eat this independently. We observed that the person was coughing while eating the foods provided. We asked another staff member if the person should be eating these foods. The staff member confirmed they should not be, and on our advice they were taken from the person. We also had previously observed this person had eaten a bread product for their breakfast. We spoke with the manager about this who advised they would look into this incident. This meant when people needed specialist diets to reduce the risks of choking, it was not always provided for them.

Where people demonstrated behaviours that put themselves and others at risk, no management plans were in place to guide staff on how to support them. We saw that this led to an inconsistent approach from staff. For example, during the inspection we saw one person was verbally distressed. The person was shouting out for long periods of time and this was causing other people to be verbally aggressive towards them. There were no management plans in place for staff to follow. We observed for two hours staff reassured this person from afar however, no one went over to the person and offered support. We spoke with staff about this person. One staff member told us, "If we sit with the person it will calm them down so we do that". Another staff member said, "There is nothing we can do so we just let them call out". A visitor commented about how distressed this person could get and how little interaction they received from staff. This demonstrated that staff were not supporting this person by using a consistent approach. We spoke with the manager who told us this person was being reviewed by the community psychiatric nurse. They confirmed there were no management plans in place for this person.

This is a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014

We saw there were procedures in place to report concerns of potential abuse to the local authority; however these procedures were not always followed. Records showed that one person had sustained an unexplained injury and another person had been 'found lying on the floor'. This incident had resulted in the person requiring an x-ray. A further incident had been recorded where another person had 'been found on the floor'. We spoke with staff who told us this person could not mobilise independently and did not know how this type of incident may have occurred. The staff we spoke with confirmed these had not been reported to the local authority. We discussed this with the manager and they confirmed that these incidents should have been investigated and possibly reported to the local authority. This meant we could not be sure the necessary professionals were informed or that people were suitably protected from potential abuse.

This is a breach of Regulation 13 (1) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014

People were happy with how they received their medicines. One person said, "The nurses come around with their trolley, they are very good with tablets". We saw staff administering medicines to people in a safe way. Staff spent time with people ensuring they had taken them. We saw that when people were prescribed medicines on 'as required basis', there was guidance in place for staff to show when these should be given and this was offered to them. We saw there were effective systems in place to store administer and record medicines to ensure people were protected from the risks associated to them.

There were safe recruitment procedures in place. One member of staff who had recently started working in the home told us, "I had to wait for my DBS and wait for references before I could start working here". The Disclosure and Barring Service (DBS) is the national agency that keeps records of criminal convictions. We looked at four recruitment files and we saw pre-employment checks were completed before staff were able to start working in the home. Checks were also completed by the provider to ensure nurses had the relevant registration qualification to work within the home. This demonstrated there were recruitment checks in place to ensure staffs suitability to work within the home.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection of Vicarage Court Nursing Home on 28 July 2015, the provider was not working within the principles of The Mental Capacity Act 2005. When people were unable to consent, capacity assessments and best interest decisions were not always completed. This was a breach of Regulation 11 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection the provider had not made the necessary improvements.

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 or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the provider was working within the principles of MCA. When people were unable to consent, we saw capacity assessments and best interest decisions had not always been completed. For example, we were told by staff that one person had covert medicines. Covert medicine are medicines which are given to a person without them being aware, such as disguised within food or drink. We saw there was guidance in place for this signed by the GP. However, a capacity assessment, best interest decision or consent form for this had not been completed. It was unclear from discussions with staff why the person received these medicines. For other people we saw capacity assessment had been completed. We saw that some people had been assessed as having capacity to make certain decisions. However, we then saw consent forms that had been completed by the person's relative. Staff told us and we saw there were other people who may lack capacity in certain areas, however we did not see any evidence that capacity assessments had been completed for these people. When capacity assessments were completed it was unclear what decisions were being assessed and how the decisions had been made. This meant we could not be sure the provider was always working within the principles of the MCA.

At the last inspection we found a person had a restriction placed upon them. At this inspection we found no evidence this had been reviewed and the restriction was still in place. There was still no capacity assessment or consent form in place which meant we could not be assured that action was taken.

Staff we spoke with told us they had not received training on the MCA and did not have an understanding of the process. One staff member told us, "It's when residents shout we sit with them". Another staff member said, "I haven't had training, but I thinks it's about end of life care". We looked at training records and could not see MCA training was recorded; we spoke with the manager who told us MCA training was undertaken as part of the safeguarding training. We saw around 60% of staff had not received training or there training was out of date in this area. This demonstrated staff did not have an understanding of the process to follow when people lacked capacity to make their own decisions.

This is a continuing breach of Regulation 11 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014

Staff we spoke with did not have an understanding of DoLS and were not aware if any people living in the home were being restricted unlawfully. One staff member said, "I don't know what it is". Another staff member gave an example of what they thought DoLS were they said, "We check the weather when we are supporting people so we ensure they are wearing suitable clothing for that day". We spoke with the manager they were unable to tell us or show us who had an authorisation in place. They gave example of people they thought they had applied for however could not provide any evidence of this. We saw evidence in one person's file that a DoLS application had been made. We also saw further evidence that for some people capacity assessments had been completed and they had been assessed to have capacity, however application for DoLS for these people had been considered. The manager confirmed there were no risks assessments in place for the people who DoLS may have been applied for, to ensure people were supported in the least restrictive way whilst these were considered. After the inspection visit we reviewed the PIR the provider had sent to us, this showed us that two DoLS approvals had been made. This meant we could not be sure people were being support in line with these.

This is a breach of Regulation 13 (5) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014

At the last inspection people told us the food was not always warm when served. At this inspection we found improvements had not been made. We observed at breakfast hot food was brought into the communal area. Some of this was wrapped in foil and other food was covered in paper. The food was on the side 15 minutes before the staff undid the wrapping and started serving it. The wrappings remained open and the last person was served their breakfast 50 minutes after the food had arrived. We spoke with people about this. One person said, "It's not quite warm". Another person commented, "Wet toast and cold eggs, I will just stick to cereal tomorrow".

When people needed support from other healthcare professionals referrals were not always made in a timely manner. For example, it was identified in one person's file that they should be weighed monthly as they 'were reluctant to eat'. We looked at records for this person. We saw documented in July 2016, this person had lost weight. There was an action that this person should be referred back to the dietician. We did not see any evidence to confirm a referral had been made and the manager and nurse confirmed this person had not been seen by the dietician.

People told us they were offered choices at mealtimes and could have alternatives if they wanted. One person said, "The foods okay, you get a selection". Another person said, "I like a bacon sandwich so they do one for me on a Tuesday and Saturday".

Staff received training and an induction that helped them to support people. One staff member said, "I have had moving and handling training, it was a practical session so was really helpful". One member of staff who had recently started working within the home told us about their induction. They said, "I had an induction for a month. I shadowed the staff for two to three weeks which was really good. I got to find out all the different ways for the people who live here. I then gradually stared doing some tasks and the job by myself". We spoke with the manager about training. They told us since they had started they had introduced '15 minute training'. This was training sessions that they would deliver to staff within 15 minutes while they were on breaks or at the start of shifts. They also told us that all new starters were undertaking the care certificate as part of the induction. The care certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to

provide people with safe, effective, compassionate and high quality care.

Requires Improvement

Is the service caring?

Our findings

People were not always supported in a kind and caring way. We observed one person was transferred by two staff using specialist equipment. We observed staff did not speak with the person or offer them reassurance during this process. We spoke with the person afterwards who told us, "It's a bit scary; you have your life in someone else's hands, I think a few words may have helped". We observed conversations were based on tasks that staff needed to complete with people. For example, at breakfast time we heard one member of staff say, "Come on now eat your breakfast". We did not see the staff member offer support to this person or encourage them to eat. We observed the person did not eat their breakfast and another staff member removed this from them. One relative commented, "Sometimes I feel staff could interact with people a little more, they are busy so it's like a quick passing comment".

People's privacy was promoted. For example, we saw staff knocking on people's bedroom doors before entering their rooms Staff gave us examples of how they promoted people's privacy. One staff member said, "It's important to maintain people's privacy and dignity as it's communal living. When I support people I shut the doors and curtains and take my time".

People told us they made choices about how to spend their day. One person said, "I like to spend some time in the afternoon in my room, I have an hour on my bed and watch my TV, that quiet time is important to me." Another person said, "I walk to the shop every morning, it keeps me active and I fetch the newspaper". We observed when people preferred to stay in their rooms they were able to do so.

We observed that people were encouraged to be independent. For example, people were encouraged to eat their meals themselves. One person said, "I do all I can myself the staff are just my reassurance" Another person told us, "I like it here as they don't do everything for me. Sometimes I am tired and don't feel like doing it myself, but they are patient and encourage me to".

People were encouraged to keep in contact with people that mattered to them. One visitor said, "I come every morning. I can come anytime I like for as long as I want". We saw that some people had mobiles phones next to them so they could keep in regular contact with friends and family. We observed that people received and made calls. We saw friends and family visited freely throughout the day and were welcomed by staff within the home.

Requires Improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Vicarage Court Nursing Home on 28 July 2015, some people were not offered the opportunity to participate in activities they enjoyed. At this inspection the provider had made not made the necessary improvements and other areas of improvement were identified.

People were not always given the opportunity to participate in activities and pastimes they enjoyed. One person said, "We had a Halloween party yesterday and it was wonderful, I only wish there was more to do". Another person told us, "I think the new manager is looking at us doing more things which I look forward to". During the inspection we observed a bingo session was taking place. One person told us, "We are having the special treatment today as you are watching". A relative confirmed that activities did not always take place in a morning. We saw an activity rota displayed in the communal area that identified that external singers visited the home on a monthly basis. One person confirmed this happened and commented, "They are very good days, we all have a sing a song". We spoke with the manager who recognised there could be more opportunity for people to participate in activities they enjoyed. They confirmed there was not an activity coordinator in post. They told us they were in process of employing an apprentice who would by employed as an activity coordinator.

People were not always involved with reviewing their care. One person said, "I haven't been involved with reviewing my care up to yet. I would get involved if I was asked". Another person told us, "No the staff and nurses sort all that out, I may have a file I'm not really sure". A relative confirmed they were updated by the home if anything happened, however they confirmed they had not been involved with any meetings or care reviews. The care files we looked at did not show if people had been involved with the planning and reviewing of their care. We spoke with the manager who confirmed people were not involved with the reviewing of the care. They commented, "We need to get better".

People and relatives knew how to complain. One person said, "I would talk to the staff". A relative told us, "I would go in the office; the new manager seems approachable so I'm sure I would be listened to". We saw the provider had a complaints policy in place. When needed we saw complaints had been responded to in line with this policy. For example, we saw a complaint had been made and the provider has responded to the complainant and looked into the concerns raised.

People told us staff knew about their needs and preferences. One person said, "They know me well, I have lived here a long time now so they get to know you". We heard a member of staff ask a person if they would like a drink. They said, "Its black, no sugar that right isn't it". The person replied, "You've got it". There were daily arrangements in place to keep staff informed about people's needs. A staff member told us that, "We have a handover, and we share information about what's happened".

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Vicarage Court Nursing Home on 28 July 2015, we found there were systems in place to monitor the quality of the service. However these had not been consistently completed. The provider had not made the necessary improvements.

The service did not have a registered manager in post. The provider had recently promoted a nurse into this role and they told us they would be registering with us, this application had not been started. The provider had not had a registered manager in post since our last inspection. Staff told us the high turnover of managers had impacted on the service. One staff member said, "It must be four in the last year and I have no idea in the last three or four years there have been loads". They went on to say, "It's just inconsistent, we start to do something and things change and then a week later it changes again and we start all over again". Another staff member told us, "It hard, everything is always different". Due to the changes that had been implemented at the service, the manager was not aware of the action plan that had been submitted to us by the provider and therefore not all actions had been completed.

There were some systems to monitor the quality of the service. However we could not be sure these systems were effective to bring about improvements. For example there was a medicines audit in place which the manager told us was completed every six months. We looked at medicines and as the provider was only completing stock checks every six months we could not be sure how many medicines people had and if they were receiving this as required. We could not be sure people received creams as prescribed. When people were prescribed creams the nurse told us care staff would administer these. There was no topical administration record in place or documentation to show if people had received these medicines. The manager told us they had identified this was an area that needed improvement and were looking at introducing monthly medicine audits.

We looked at incidents and accident records for the home. When incidents had occurred we did not see that action was always taken to mitigate further risk. For example, on one incident form it was documented that a person had hurt a staff member. There was no action recorded on the incident form to reduce the risk of this reoccurring. We looked at records for this person. There was a care plan in place, identifying the person may demonstrate this behaviour. However no review had taken place since the incident had occurred. Another incident had occurred where a person had spilt a hot drink on themselves. We looked at records for this person and there was no evidence of this risk in their care file. We discussed this with the manager who confirmed risks assessments and care plans were not reviewed following incidents. This showed us that staff were not provided with guidance on how to support a person safely when their needs changed.

When people needed their fluid intake to be monitored we saw fluid balance charts were in place. There was no guidance in place to identify how much fluid people should be receiving. We looked at records for these people. It was documented that one person had only received 620mls of fluid over a 48 hour period, for another person they had 850mls documented. We spoke with staff who confirmed they did not review the information that was documented. One staff member said, "We just write down when someone has had a drink and how much. We don't really do anything with the charts; I think the nurses would look at them". We

spoke with a nurse who told us, "The staff would usually handover if they were concerned about someone's fluid intake". Records showed us that people would receive their last drink at around 7pm on an evening and their next drink would not be documented till around 8am the next day. As this information was not reviewed we could not be sure people were receiving adequate fluids.

This is a breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014

We could not be assured that the provider understood the responsibilities of their registration with us. We spoke with staff about notifications; they were unclear on some of the areas that should be reported to us. Furthermore staff told us about an on-going safeguarding concern within the home and we had not received a notification in regards to this.

This is a breach of Regulation 18 (4) (B) of the Care Quality Commission (Registration) Regulations 2009.

Feedback was sought from people who used the service and their relatives. We saw a questionnaire had been completed in September 2016. The provider used this information to make changes to the service. For example, we looked at the questionnaire that had recently been completed. One of the areas that had been identified as requiring improvement was the lack of activities within the home. The manager told us from this they were recruiting an apprentice to work as an activity coordinator. This recruitment process was underway. This meant the provider sought the opinions of people who used the service to make changes.

Staff we spoke with were happy to raise concerns and knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices. One member of staff said, "It's when staff do something wrong and you report it without anyone knowing". We saw there was a whistle blowing procedure in place. This showed us that staff were happy to raise concerns and were confident they would be dealt with.

Staff and relatives told us they were happy with the new manager and they had made some positive changes. One relative said, "They seem nice, they are always around and available so that's good". A staff member told us, "We have changed the daily files and they are much easier to follow". Another staff member said, "We have had a staff meeting the other day, which was good". Staff confirmed they felt they would be listened to in the future. The last inspection report and ratings were displayed in a conspicuous position in line with our regulations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We could not be assured that the provider understood the responsibilities of their registration with us as we had not been notified of a safeguarding concern at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We could not be sure the provider was working in line with MCA. As capacity and best interest decisions had not always been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not managed in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We could not be sure the necessary professionals were informed when potential safeguarding concerns arose or that people were suitably protected from potential abuse. Staff did not have an understanding of DoLS and we could not be sure people were being

supported in line with authorisations that were in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was not a registered manager in post. There were some systems to monitor the quality of the service. However we could not be sure these systems were effective to bring about improvements. Records were not always reviewed to ensure people were safe and receiving care and support as they required.