

Lawton Group Limited

Glebefields Care Home

Inspection report

Stratford Road
Drayton
Banbury
Oxfordshire
OX15 6EH

Tel: 01295738133

Website: www.brighterkind.com/glebefields

Date of inspection visit:

13 June 2018

19 June 2018

Date of publication:

17 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 13 and 19 June 2018 and was an unannounced inspection.

Glebefields 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. Glebefields accommodates up to 48 people in one adapted building. At the time of the inspection there were 39 people living at the service.

There was not a 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.

There was not always sufficient staff to meet people's needs. There was not an effective system in place to monitor call bell response times. The provider's procedures to formally assess, review and monitor the quality of the service were not always effective.

People were supported by staff who had been trained in the MCA. However staff did not always apply the principles of the Act in their work. Staff did not always follow the recommendations made by healthcare professionals. Records relating to people's care did not always capture person centred information; and care records were not always clear and concise.

People were supported appropriately to eat and drink sufficient amounts to help maintain their health and well-being. However, people gave a varied response about the choice of food at Glebefields.

People told us they were safe living at Glebefields. Staff demonstrated they understood how to keep people safe and we noted that risks to people's safety and well-being were managed through a risk management process.

People were very complimentary about the staff and management at the home. They told us staff were kind, caring and compassionate. Visitors were welcomed at all times and people were supported to maintain family relationships.

People's health care needs were met and they had access to a range of healthcare professionals. Where required, appropriate referrals were made to external health professionals, such as GP's or therapists.

The provider had systems in place to receive feedback from people who used the service, their relatives and staff members about the service provided. People were encouraged and supported to raise any concerns with staff or management and were confident they would be listened to and things would be addressed.

Staff told us, and records confirmed they had effective support. Staff received regular supervision (one to one meetings with their manager) and yearly appraisals. The provider had safe recruitment processes in place, which helped to ensure that staff employed were of good character and suited to the roles they were employed for. People's medicines were managed safely and kept under regular review. Infection control measures were in place to help reduce the risks of cross infection.

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. There was not always sufficient staff to meet people's needs.

There was not an effective system in place to monitor call bell response times.

Staff were aware of how to safeguard people from harm and were aware of potential risks and signs of abuse.

Staff administered medicines to people in line with their prescriptions.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People were not always supported in line with the principles of the MCA.

Staff did not always follow the recommendations made by healthcare professionals.

Staff had the training, skills and support to meet people's needs.

Requires Improvement ●

Is the service caring?

The service was caring.

Staff were kind and respectful and treated people with dignity and respect.

People benefited from caring relationships.

The staff were friendly, polite and compassionate when providing support to people.

Good ●

Is the service responsive?

The service was not always responsive.

Care plans did not always capture person centred information.

Requires Improvement ●

Peoples care records were not always clear and concise.

There was a wide range of activities for people to engage with.

Is the service well-led?

The service was not always well led.

The provider did not have effective systems in place to monitor the quality of service.

The service did not have a registered manager.

The service encouraged open communication between the staff team.

Requires Improvement 

Glebefields 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 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 13 and 19 June 2018 and was an unannounced inspection. This inspection was conducted by one inspector, a specialist advisor, whose specialism was nursing and Expert by Experience (ExE). An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider 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 looked at previous inspection reports and notifications received from the provider. A notification is information about important events, which the provider is required to tell us about by law. This ensured we were aware of any areas of concern.

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 spoke with 10 people, four relatives, four care staff, one nurse, the chef, one administrator, the regional manager, the regional support manager, operations support manager, the deputy manager and Chief Operating Officer. We looked at nine people's care records, six staff files and medicine administration records. We also looked at a range of records relating to the management of the service.

Is the service safe?

Our findings

We observed, and records confirmed, there was not always sufficient staff to meet people's needs. One person told us, "I am sometimes left waiting for help". A second person told us, "They cope with staff shortages but there aren't enough. There are lots of agency staff at night and there's no continuity with many of them". A third person said, "There is a problem with staff numbers, the other day there were two instead of five". A fourth person said, "I call for staff and they don't come. There are not enough staff though I'm told they are fully staffed. I sometimes wait an hour for care. It can be 11.30am before I get help with washing".

The manager and provider used a 'dependency tool' when carrying out ongoing assessments on people's care needs. The purpose of the dependency tool was to support the manager to calculate the right ratio of staff against people's needs. We saw that individual dependency tools were consistently updated by nurses. However, the manager and provider had failed to review this appropriately and as a result the service did not have the correct ratio of staff to support the needs of people in the home. For example, one person's individual dependency tool showed that they had been rated as having a high level of support needed in relation to their mobility. However, their level of dependency for mobility had been entered into the system used to calculate staffing ratios as medium. We found a further 32 examples where five people's individual needs in relation to medication, mobility, personal care, continence, nutrition and skin integrity had been incorrectly matched to staffing levels. This meant that staff were rushed in their duties because the manager and provider had not ensured that staffing was planned safely and effectively.

We observed the midday meal experience on the unit supporting people living with high support needs. Three people required supervision and support to have their meals were being supported by one staff member. This meant that the staff member had to divide their attention between all three people and we saw this was not effective. Two people consistently fell asleep and did not eat when the staff member's attention was with the third person. We discussed this with the staff member and they told us, "It's good today [staffing], it's not usually this good. There is not enough staff. Some days there is no one in here [dining room] because we have to help [people who require support in their rooms]". During our lunch time observation, we noted that two people who require support with their meals were left unattended with no staff interaction for 19 minutes.

Throughout the inspection we observed that staff were task orientated. One member of staff told us, "There is not enough staff to deal with the levels of need. We especially need more night staff. I feel rushed especially when I need to do things like medication and contact people's GP's". Another staff member said, "No [we don't have enough staff]. It means I don't have that extra ten minutes with people. It makes you feel tired, unwell and stressed". We raised our concerns with a member of the provider's management team and they told us, "We have raised this with [provider]. [Provider] takes too long to do things, this is not safe", "We are not fulfilling our responsibilities because we don't have enough time to spend good quality time with people".

One person described the impact of a recent incident where there was not enough staff on duty. The person

told us that they had sat with another resident who was distressed. They told us that they had waited with this person for one and half hours. They said they had asked for help but were told by staff that they needed to attend to other residents first. The person also told us, "There are not enough staff, no doubt about that. Carers walk by without acknowledging me. They only do what they've got to do, they take me somewhere and then disappear. I can look after myself but people in wheelchairs are just dumped. Staff don't sit in the lounges with residents".□

We looked one person's care records who required the support of two staff members during moving and handling tasks. The person had complained that they were left unattended during a moving and handling task and as a result suffered a fall. A transcript from the person's complaint which was in their daily records stated 'that [person] is left for hours and hours unattended when needing the toilet'. We raised this with the provider and they told us that on the day of the incident a staff member was with the person however, the correct ratio of staff had not been deployed effectively to support this person due to staff shortfalls on that day.

Following our inspection, we were contacted by the providers Chief Operating Officer and given assurances that these concerns had been identified and actions would be taken to address these concerns. However, this was not in place on the day of our inspection.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Throughout the day the call bell system was constantly alerting staff to people who required support. Due to this and our findings in relation to staffing levels and what people told us we asked the provider to supply evidence that call bells were being responded to effectively and timely. Having initially been informed by the provider that this would be provided, another member the provider's management team and they told us, "Three and a half years ago is when the last check was. In fact you could say 10 years. We have no way of telling if staff are responding to people" and "We don't have a system in place to check this". In the absence of an effective system the provider was unable to assess the effectiveness of staff in relation to response times.

The failure to have effective systems and processes in place to monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Following our inspection we were contacted by the providers Chief Operating Officer and given assurances that they would address this immediately and seek feedback from other homes run by the provider to ensure the correct systems were in place to monitor call bell response times.

Although the service was not always safe, people told us they felt safe. One person told us, "I feel safe, but I'm alright as I can do a lot for myself". A second person told us, "It's a good place. I'm safe and secure". A third person said "I feel safe and secure but independent. I can sit outside if I want".

Staff were aware of how to safeguard people from avoidable harm and were knowledgeable about signs of potential abuse. Staff were able to describe the process for reporting concerns both within the service and externally, if required. One staff member told us, "I would report anything straight to my manager or contact the social services team".

People's care plans contained risk assessments, which included risks associated with moving and handling,

falls, medication and pressure damage. Where risks were identified plans were in place to identify how those risks would be managed. For example, one person was at risk of pressure damage. The person's care record gave guidance for staff on the use of pressure relieving equipment. We observed staff following this guidance and supporting the person effectively.

We saw there was information about how to report concerns, displayed in areas of the home, which reminded staff of the contact numbers they needed to report concerns. Systems were in place which protected people against the risks related to the fire safety. For example, people had personal evacuation plans in place to support staff to evacuate or keep people safe in the event of an untoward incident or an emergency such as a fire.

People we spoke with told us they received their medicines as prescribed. One person told us, "I get my medicine every day at 7.15am". A second person said, "I get my medications every day and they watch me while I take them". A relative told us "We are very confident about the nursing care". Records relating to the administration of medicines were accurate and complete. Where people were prescribed 'as required' medicines (PRN), protocols were in place to identify when PRN medicines should be given.

One person sometimes needed to receive their medicines covertly (medicine which is put in food or drink without the person knowing). Records confirmed that a covert administration assessment had been completed and was reviewed regularly by the home. We noted that the G.P and community pharmacist had been involved in a 'best interest' meeting to ensure that the decision to carry out covert medication was carried out safely.

Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC). A nurse we spoke with told us "I completed my revalidation last year".

Safe and effective recruitment practices were followed to help make sure that all staff were of good character and suitable for the roles they were employed for. We checked the recruitment records of five staff and found that all the required pre-employment checks had been completed prior to staff commencing their employment. This included a completed application form, two written references and disclosure and barring check (DBS). The DBS check helps employers make safe recruitment decisions and prevents unsuitable potential employees from working with vulnerable people.

People were protected from the risk of infection. The premises and the equipment were clean, and staff followed the provider's infection control policy to prevent and manage potential risks of infection. Colour coded equipment was used along with personal protective equipment (PPE). PPE equipment, such as aprons and gloves were available and used by staff. We observed good hand hygiene practices. Wall mounted hand sanitizers were filled and were available throughout the home, and in the individual rooms of people with high levels of dependency. One person we spoke with told us, "The place is always kept spotless".

Is the service effective?

Our findings

People's needs were assessed prior to their admission to ensure their individual care needs could be met in line with current guidance and best practice. People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. Where people had been identified as having mobility difficulties, referrals had been made to physiotherapy. Care plans contained details of recommendations made by physiotherapists. However staff did not always follow the recommendations. For example one person who was at high risk of falls had been supplied chair raisers to reduce their risk of falls. Chair raisers are designed to make a piece of furniture higher as this puts the hips above the knees and makes it easier to stand from sitting. Therefore reducing the risk of falls whilst moving from a sitting position to a standing position. This person had recently moved rooms within the service, however staff had failed to move the person's chair raisers. This meant that the person increased their risk of falls. We spoke with this person who was clearly frustrated about this. We also spoke with the person's physiotherapist and they told us "The recommendation (to use chair raisers) has not been followed, it's frustrating". When we raised this with the provider they took immediate action and moved the person's equipment to their new room. We asked the provider to confirm how long this person had been without their chair raisers. However the service did not have a record of when the room move took place.

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were supported by staff who had been trained in the MCA. Where appropriate people's care plans contained capacity assessments. Where decisions were made on people's behalf, we saw evidence that on most occasions the service followed the best interest process. However we found an example where a person's relative had consented to elements of their care without having the correct legal authority to do so. We raised this with the provider and we were given assurances that this would be addressed.

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 found the home met the requirements of DoLS.

Staff received regular supervision, which is a one to one meetings with their manager and yearly appraisals. However staff told us they did not always feel supported by the management team and the provider. One staff member told us "I feel supported by other care staff, but not by the provider". Another staff member said "No I don't feel supported". When we explored this further with staff they explained that they had raised concerns surrounding the pressures they were under, but did not feel they were being listened to.

Throughout the inspection we raised our concerns with the management team. Following our inspection we

were contacted by the providers Chief Operating Officer and given assurances that these concerns would be addressed immediately and they would conduct a staff survey to help identify how best to support staff.

Newly appointed care staff went through an induction period which reflected the Care Certificate. The Care Certificate is a set of standards that social care workers are required to work to. It ensures care workers have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. This included training for their role, shadowing an experienced member of staff and having their competencies assessed prior to working independently with people. One staff member told us, "I had to shadow other staff before I could do it alone".

Records confirmed people were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff completed training, which included safeguarding, moving and handling, infection control, medication management, first aid, fire awareness and food and hygiene. One staff member told us, "We get regular training".

People told us they did not find meal times an enjoyable experience because the menu did not always reflect their personal choices. The chef told us all the food was freshly prepared and the service operated a menu cycle. We were told that people were involved in decisions about the menu so that favourite meals could be included when preparing new menus. However when we spoke with people about the menus and the food served we were given a varied response. One person told us "The chef is very good, I can't really complain about the food though the menus could be more varied and creative. Apples are always out of a can, there's not much fresh food. We have winter type food even in the summer. It would be good to have lighter options, salad and so on". A second person said "The food is reasonable, I enjoy it". A third person told us "I'm not very happy with the food. It's not my scene. I like plain food but the chef is very helpful and accommodates my preferences. The menu comes from head office and it's not suitable for me". A fourth person said "The food is very good and there's plenty of choice". Due to the varied response from people we asked the chef and a member of the management team to evidence peoples input into the meals provided. However they were unable to provide this. Therefore we could not be satisfied that people were involved in the development of menus and the meals provided.

During our observation of the lunch time meal we noted that people were offered a choice of drinks throughout. Where people required special diets, these were provided by the chef who clearly understood the dietary needs of the people they were catering for. Snacks were available for people to have in between meal times.

We observed that the environment was suitable to meet people's needs and there was a homely feel about the service. The dining rooms and communal areas were spacious and decorated in a homely fashion. Rooms we observed had been personalised and made to look homely.

Is the service caring?

Our findings

People told us they benefited from caring relationships with the staff who supported them. One person told us, "The staff are kind but they are ever so rushed". Another person said, "I like the staff, they work their socks off. Couldn't better it, this place. I've no complaints at all. They couldn't do anything differently, they do it right". A third person told us, "The staff are fantastic, they get on with everyone and listen to any problems".

During the day of the inspection, we noted there was good communication between staff and the people who used the service. People were treated with kindness and respect by staff, who understood their individual needs. For example, one person had difficulties communicating. This person's care records gave guidance for staff to recognise and respond to the person's communication needs. During our inspection, we observed staff communicating effectively with this person. Staff gave the person the time they needed to explain what they were asking or discussing. This demonstrated that staff knew and respected the people they were supporting.

Staff showed concern for people's wellbeing in a caring and meaningful way. For example, one person became anxious. Staff spoke with this person and gave them reassurance and held the person's hand. As a result the person became less anxious and their mood improved. Throughout the interaction staff spoke with this person in a warm and gentle manner.

Staff told us they respected people's privacy and dignity. One staff member said, "We treat people as we would want to be treated ourselves. We cover [people] up to protect their dignity". Another staff member told us, "We always knock on doors at the end of the day it's their personal space". One person told us, "I've been in three care homes and there is dignity and compassion here. I'm satisfied with what I'm getting, it's the best place I've been in". Another person said "I asked for personal care from women only and this is what happens".

Staff spoke with people with respect using the people's preferred names. When staff spoke about people to us or amongst themselves they demonstrated compassion and respect. During our inspection we noted that staff were always respectful in the way they addressed people. We observed staff knocking on people's doors and where people had their doors open staff still knocked and waited to be invited in. One person told us, "They always knock".

Care records highlighted what people could do for themselves in order to remain independent. This included aspects of personal care, mobility and getting dressed. Where the need to promote independence had been highlighted, there was guidance for staff on how to prompt and support people effectively. We observed staff following this guidance. Staff told us how they supported people to do as much as they could for themselves and recognised the importance of promoting people's independence. One staff member we spoke with told us, "Independence is important it's what keeps people going".

Staff understood and respected confidentiality. Records were kept in locked cabinets and only accessible to

staff.

Is the service responsive?

Our findings

People told us that the service was responsive to people's needs. One person told us; "If there is a problem then they get me checked out and looked at". A relative said, "We are very confident about the nursing care". The service was responsive to people's changing needs. For example, during our inspection we observed staff recognising that one person had developed a chesty cough and a change in their breathing. Staff reported this to the nurse on duty and as a result a GP appointment was arranged for that afternoon. The impact of this was that the person's health needs were addressed.

Care plans captured people's preferences, likes and dislikes. However, care records did not always capture person centred information about people's backgrounds, hobbies and interest and daily routines. For example, all of staff we spoke with told us how people liked to spend their time and what was important to them. However, the information shared with us by the staff members was not contained in within people's care plans. This meant that new staff or agency staff may not easily obtain the person-centred information to support people effectively.

Most records we looked at were handwritten and were not always legible. For example, we looked at six people's care records and found that daily records were not clear or unreadable. We asked two members of the providers management team if they could read what was written in the notes. They confirmed that they could not and acknowledged that this needed to be addressed. The impact of not always having clear and concise care records means that staff cannot always access up to date and accurate information about peoples care and wellbeing. We were given assurances by the provider that this would be addressed.

We asked the provider to provide evidence of how the service ensured it worked within the Accessible Information Standard (AIS) framework. AIS was introduced by the Government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. The provider was not aware of AIS. However, after we explained AIS they were able to demonstrate to us an example of where information relating to people's care had been supplied in large font to support people with poor eyesight.

People had access to a wide range of activities that included live entertainment, puzzles and board games. The service had an activity's coordinator who was responsible for day to day activities. People were smiling and laughing and enjoying the social interactions with the activities coordinator. People spoke positively about the activities provided. One person told us, "The coordinator does a good job". A second person said, "There is a varied programme. I like the art and would like more. I also like the music". A third person told us, "There are lots of activities, quizzes, musical, whatever and I've made friends". A relative we spoke with said, "[Person] is keen on the one two one activity she is offered by the coordinator. It focuses on memory, dexterity and stimulation".

People's diverse needs were respected. Discussion with the provider and staff showed that they respected people's individual needs. We saw an example of two people at the service had strong links with a different country. The service arranged for specific food to be provided to these people. We also noted that people of

different faiths were supported to follow their faith in a way they choose to. We spoke with one of these people and they told us, "They certainly know me as an individual and give me what I need". A staff member said, "We treat everyone as a unique individual". The services policies and procedures supported these practices.

People knew how to make a complaint and information on how to complain was available in the home. One person told us, "If I had a problem, I'd just tell one of them". Another person said, "If I had a problem, I'd just pop into the office. I don't know the manager. But I'm 100% confident problems would be sorted". Records showed that where complaints had been made they had been dealt with in line with the provider's complaints policy.

At the time of our inspection there was no one receiving 'end of life' care. However, the provider was able to evidence how the service had previously recorded and respected people's preferences and wishes. Records confirmed that people's funeral wishes in relation to burials, cremations and family arrangements had been discussed with people.

Is the service well-led?

Our findings

The provider did not have effective systems in place to monitor the quality of service. For example, the provider's quality monitoring system had not identified the concerns relating to the call bell system, staffing levels, inappropriate consent and illegible records.

We saw evidence that the provider had a procedure in place to formally assess, review and monitor accident and incidents at the home. However, this procedure was not always followed. For example, the providers accident management policy stated that all 'Incidents and near misses will be investigated within 20 working days of submission of the incident report form'. We found 49 incidents and accidents that had been reported by staff which had not been investigated and reviewed by the home manager within 20 working days. The impact of this is that the system that was in place to analyse and assess the quality of the care provided to people was ineffective.

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

Following our inspection we were contacted by the providers Chief Operating Officer and given assurances that these concerns would be addressed immediately.

The service did not have a registered manager. 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. However, we noted that a new manager had been appointed and they were going through the registration process.

Although the service was not always well led, people told us they enjoyed living at the service and were positive about the management team. One person said, "The overall management is good, they cope with staff shortages". Another person said, "It's well managed now. A year ago it was without a manager for a year. We've had different ones and they change things and mess them up, It's very good now, the manager and deputy are good". A relative we spoke with told us, "It is managed quite well. [Person] is well supported".

The service encouraged open communication between the staff team. A staff member told us, "We have regular meetings". Another staff member said, "We get together and talk about what needs doing". We viewed the team meeting minutes, which showed that staff had regularly met to discuss people's individual needs and to share their experiences. However although there were formal mechanisms in place to encourage communication staff did not always feel that they were listened to.

The home sought people's views and opinions through residents and relative's meetings. We viewed records that confirmed these meetings were taking place. One person told us, "The manager invited us all to a meeting last week. Everyone went. Everything was discussed". Another person said, "I went to the recent

residents meeting and I was interested and agreed with the answers given by the staff". People we spoke with told us they felt confident in giving feedback on the service and that they would feel listened to.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. One staff member told us, "I would whistle blow if I had to".

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of reportable events.

The service worked in partnership with visiting agencies and had links with GPs, the pharmacist, and CHSS.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor the quality of service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet peoples needs.