Mr & Mrs Allison

Beachville West End

Inspection report

Beachville Care Home
West End
Newbiggin-by-the-sea
Northumberland
NE64 6XD

Tel: 01670817345

Date of inspection visit:
07 January 2016
11 January 2016

Date of publication:
14 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Beachville West End is a residential care home based in Newbiggin-by-the-sea, Northumberland which accommodates up to 13 older people, some of whom are living with a form of dementia. The service was last inspected in April 2014 and there were no breaches of legal requirements at that time. There were 13 people living at the home at the time of our inspection.

There is a condition on the provider's registration of this service that a registered manager must be in place. At the time of our inspection there was a registered manager in post who had been managing the service for many years and been registered with the CQC since October 2010. 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. We were assisted at our inspection by both the registered manager and provider, both of whom were present on the days that we visited the home.

People told us they were happy with the care and support they received and they felt safe. Staff were knowledgeable about what constituted a safeguarding incident and confirmed how they would handle any safeguarding matters should they arise. Staff had been trained in safeguarding and we saw that historic safeguarding incidents had been handled and reported appropriately and in line with protocols and procedures. People were supported to meet their nutritional and hydration needs and staff monitored people's weights to ensure they remained healthy, seeking input from GP's and dieticians where necessary.

Risks that people had been exposed to in their daily lives had been assessed and these were regularly reviewed. Accident and incident monitoring took place and where necessary risk assessments were amended to prevent repeat events. Care records were personalised and highlighted how people should be supported safely and in line with their needs, likes, dislikes and preferences. They were regularly reviewed and up to date. Care was person-centred and there was evidence that people and their relatives were involved in their care. No person had a formal advocacy agreement in place but the manager was aware of how to arrange this should it be necessary.

People, staff and our observations confirmed that there were enough staff on duty to meet people's needs. Staff confirmed they were not rushed when delivering care. They had received training in key areas and supervisions and appraisals were carried out regularly. Recruitment processes were thorough and medicines were managed well.

Our observations confirmed people experienced care and support that protected their privacy, dignity and staff promoted people's independence. Staff displayed caring and compassionate attitudes towards people and they enjoyed good relationships. Activities were available to stimulate and occupy people. Choice was evident throughout the service; for example, people chose where they spent their time and the foods they liked to consume.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' and it also ensures that unlawful restrictions are not placed on people in care homes and hospitals. The MCA was appropriately applied and applications had been made to the local authority for those people who required assessment for a deprivation of liberty safeguard to be put in place. There was evidence within people's care records that their consent was sought before care was delivered.

Some systems were in place to monitor the service provided and care delivered but these were limited and did not identify and address environmental risks within the home. A legionella risk assessment and control measures were not in place and there was no evidence that an electrical installation check had not been carried out. We also identified some fire safety issues within the home which we referred to Northumberland Fire and Rescue Service, Fire Safety Department. By the end of our inspection the provider had taken steps to address all of the issues and shortfalls that we had identified and informed them of.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 12, Safe care and treatment, and Regulation 17, Good governance. You can see what action we told the provider to take at the end of the full version of this 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.

Environmental risks within the premises had not always been considered and assessed and there were a number of fire safety considerations that had not been identified by the provider.

Staff and people told us there were enough staff to meet people's needs. Recruitment procedures were robust and medicines were managed appropriately.

Safeguarding procedures were in place and staff were aware of their personal responsibility to report matters of a safeguarding nature.

Is the service effective?

Good

The service was effective.

Staff were supported with training in key areas and supervision and appraisal was carried out regularly.

People were happy with the care they received and their relatives reported that they had no concerns about the service.

The Mental Capacity Act 2005 was appropriately applied.

People were supported appropriately with nutrition and hydration.

Is the service caring?

Good

The service was caring.

Staff engaged with people respectfully and politely. People's dignity and independence was promoted.

People and their relatives were involved in their care.

Staff provided people with information and explanations and supported and encouraged them when going about their daily lives.

Is the service responsive?

Good

The service was responsive.

People had individualised care records that were informative and specific to their needs.

Choice was promoted within the service and people told us activities were offered for them to partake in if they so wished.

There was a system in place to deal with complaints but people told us they had not made any formal complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Limited auditing of the service took place and there was a lack of effective systems in place to identify risks within the service.

Staff described an open culture and a provider and manager that were approachable.

People told us the service was well led.

Beachville West End

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 7 and 11 January 2016 and was unannounced. The inspection team consisted of one inspector.

We did not request a Provider Information Return (PIR) from the provider in advance of this inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. Prior to our inspection we reviewed all of the information that we held about the service including notifications that had been sent to us about deaths and other reportable incidents such as safeguarding matters and incidents involving the police. Providers are required by law to submit notifications to the CQC in line with regulations under the Health and Social Care Act 2008, so we can monitor the service. We also contacted Northumberland safeguarding Adults team and Northumberland local authority contracts team in advance of our inspection, to gather their feedback about the service.

During our inspection we spoke with seven people, three visiting relatives, the provider, the manager of the service, the deputy manager, three care workers, one member of the domestic staff team and the cook. We looked at four people's care records plus a range of records related to the care delivery and the operation of the service, including health and safety records and four staff recruitment and training files.

Requires Improvement

Is the service safe?

Our findings

We identified concerns related to the safety of the premises. Environmental risks had not always been assessed and measures were not always in place to ensure that the health and well-being of people and staff was protected. For example, we identified a number of fire safety concerns including fire doors being locked and the keys not being readily accessible, meaning that people and staff may not be able to get out of the home in an emergency situation. Some doors had keypad locks between different areas of the home, which did not allow them to open automatically in the event of a fire. In addition, there was no evidence that the fire risk assessment for the premises had been reviewed since 2006. We shared our concerns during our inspection with Northumberland Fire and Rescue Service, Fire Safety Department. They have since carried out a fire safety inspection of the home and set actions which the provider must meet within a given timescale. The provider has sent us documentation to prove that they have addressed the fire safety issues raised, following this inspection.

We reviewed paperwork related to assessment of other environmental risks within the home and found some checks took place regularly such as gas safety checks and checks on equipment. The provider could not confirm or locate paperwork to prove that maintenance checks on the safety of the electrical installation within the home had not been undertaken. Portable Appliance Testing (PAT) had not been carried out on electrical items being used throughout the home since July 2014 and the provider confirmed they had not checked these items since this date. This meant the provider could not be sure that all electrical items being used by people and staff remained safe for use. In addition, the risk of legionella bacteria developing within the water supplies of the home had not been considered or assessed. There was no risk assessment in place related to this and no preventative control measures were in place, such as the testing of water temperatures and sampling of the water supplies on a regular basis. We fed back our concerns to the registered manager and provider. Immediately following our inspection the manager arranged for a legionella risk assessment to be carried out, a full electrical installation check of the premises and PAT testing.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

People told us they were happy with the care and support that they received from the service and they felt safe, both within their surroundings and in the presence of staff. One person said, "I don't feel anything like unsafe in here." Another person told us, "The staff are all very nice with me." People's relatives said they had never had any cause for concern about how people were treated by staff and they had not witnessed anything they considered to be unsafe practice, when they had visited the home. One relative commented, "It's wonderful here. We can't find any fault with anything."

Staff were knowledgeable about what would constitute a safeguarding incident and how to report any concerns that they may have about people's care and treatment. Staff training records showed that they had been trained in the safeguarding of vulnerable adults. The provider had a policy and procedure in place for staff to follow which gave them information about how to report matters of a safeguarding nature,

should they need this guidance. We identified that only one matter of a safeguarding nature had occurred within the 12 months prior to our inspection. This was handled appropriately by the service, who reported the incident to Northumberland Safeguarding Adults team for assessment and appropriate action to be taken. The manager demonstrated that she had a clear understanding of her responsibility to report matters of a safeguarding nature and this meant that people living at the home could be assured that they would be protected from harm or abuse.

Risks that people had been exposed to in their daily lives had been assessed and these were regularly reviewed. For example, where people needed support with mobility, their needs had been appropriately risk assessed. We saw where people needed walking aids such as zimmer frames to limit the risk of them falling, these had been provided and staff prompted people to use them when they forgot. Other people had risk assessments in place for the management of conditions such as diabetes and poor skin integrity. Emergency plans were in place to inform staff of what to do in the event of an emergency and there was a list of key people to contact relevant to each situation, such as plumbers and other workmen. Personal emergency evacuation plans were in place which gave information to staff about the level of support that each person would need if they were to be evacuated from the building. This meant people could be appropriately supported in an emergency situation to leave the building safely.

Accidents and incidents that occurred within the home were recorded and monitored monthly by the manager who carried out an analysis of each individual event. Records showed that where necessary measures were put in place to prevent repeat events and amendments were made to people's risk assessments.

Staffing levels were assessed to maintain a number which ensured that people's needs were met in a timely manner. Staff told us that they were not rushed in their roles and we observed this on the two separate days that we inspected. People had access to numerous staff throughout the day and we saw people did not have to wait for assistance. Staff had time to talk with people and partook in activities with them, such as singing. One member of staff said, "Staffing levels are fine. We are not pushed during our duties. There is always cover from within the staff team if people are off work, for instance if they are sick".

Staff files showed that recruitment procedures were robust and the provider carried out checks to ensure that prospective employees were suitable to work with vulnerable adults. Potential new staff submitted application forms which included their employment history, they were interviewed, references checked, identification verified and Disclosure and Barring Service checks (DBS checks) carried out. The Disclosure and Barring Service carry out vetting checks on potential employees to ensure that they have not been barred from working with vulnerable adults or children. They also provide information about any criminal convictions that potential employees may have. By carrying out DBS checks the provider was able to establish the suitability of prospective employees for the role to which they would be employed. This meant the provider took steps to ensure that vulnerable people were protected from unsuitable persons working at the service and potentially compromising their safety.

Medicines were managed safely and staff followed best practice guidance when supporting people to take their medicines. There were policies and procedures in place for staff to refer which gave them instructions to follow about the safe administration, storage, disposal and recording of medicines given. We saw that these policies were followed in practice. We cross referenced three people's medicines stocks with their Medicines Administration Records and found that the remaining balances tallied with the medicines recorded as having been administered. Where people had left the home to spend time away with their families or receive care in hospital, a robust system in place to sign medicines out and back into the home. The receiving party took responsibility for supporting the person to take their medicines. Topical medicines

such as creams and gels were prescribed to some people and body maps were in place informing staff of where people needed these medicines to be applied. Medicine audits were carried out regularly, although the records of these audits did not reflect how detailed they were in practice. We discussed this with the manager who advised that these audits would be reviewed, and amended if necessary, once they had obtained advice from the relevant healthcare professionals.

Infection control was well managed within the home and we had no concerns about cleanliness or the risk of either people or staff contracting a healthcare associated infection through inappropriate practice.

Good

Is the service effective?

Our findings

People told us that they were more than happy with the care and support that they received from the service. One person said, "They have done very canny up to now." Another person told us, "I always get help if I need it." Other comments included, "I get up in the morning and there is help there if I need it" and "I am very well looked after in here; it's lovely." People's relatives give very positive feedback. One relative commented, "It's wonderful here. X (person's name) seems to be very well looked after."

Staff demonstrated that they had a good knowledge of individual people and their needs. Training records showed that staff were equipped with the skills that they needed to fulfil their roles and they had undertaken training in key areas such as, moving and handling and infection control. We noted staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The manager told us that she would look into sourcing this important training for staff as soon as practicable. Some training had not been refreshed for some time although the manager told us training in key areas would be repeated within the next year, as this was redone on a five year basis. We found no concerns with staff competencies. Staff were knowledgeable about the topics they had been trained in and we observed that they delivered safe and effective care.

Staff competencies in the administration of medicines were tested regularly to ensure those staff with medication responsibilities remained skilled in this important area of care delivery. Appraisals were carried out annually and supervisions on an eight weekly basis. Staff told us they felt fully supported in their roles and could approach either the manager or provider at any time with any issues. One member of staff said, "You can go to X (the manager) anytime. She is approachable and understanding. I am not frightened to say anything. I feel nothing would be a problem."

There were no issues with communication within the service and staff and the manager told us they were kept fully informed. The provider was actively involved in the service. Messages were passed between the staff team via a diary/handover book. This meant staff were kept informed about people's care to ensure continuity in their care they received from different staff teams.

People were supported to eat and drink sufficient quantities of food and drink to maintain their health and wellbeing. We saw that people were supported at lunch. For example, they were asked if they needed their food to be cut up into smaller manageable pieces and where they agreed this was done for them. Food looked attractive and people seemed to enjoy what they were eating. The cook showed us a file that they retained in the kitchen which was regularly updated as people's nutritional needs changed. Some people living at the home had diabetes and we saw that one change in a person's diet that had occurred whilst we were inspecting had been relayed to the cook verbally and written in this book. There was a variety of healthy food options available to people and alternative choices if people did not like the food that was on offer. People were weighed weekly so that any fluctuations in their weight could be monitored and action taken as required. No people at the home were subject to food and fluid intake monitoring during our visit. The manager explained how this was done should it be required. This meant that people were supported with their nutritional and hydration needs and systems were in place to monitor any changes in these needs

if necessary.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. 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 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 whether the service was working within the principles of the MCA, in respect of care delivery and whether due consideration had been given to people's levels of capacity in a variety of areas. We found that decisions had been made in people's 'best interests' in line with the MCA and the manager involved people's families and care managers in any care based decisions, where necessary. For relevant persons, applications had been made to the local authority safeguarding team for assessment to see if people needed DoLS to be put in place, so that any deprivation was lawful. The manager was awaiting the outcome of these assessments at the time of our inspection. People's ability to consent had been explored and where they were able to consent themselves documentation was evident in people's care records to show that they had consented to, for example, the service administering their medication or delivering personal care. This meant the provider was adhering to their obligations under the MCA and supporting people appropriately where they were not able to make decisions for themselves.

People were supported to maintain their health and wellbeing and there was evidence that they received regular health check ups with healthcare professionals such as doctors, dentists and opticians. Where people became ill there was evidence that medical attention was sought for them and appropriate action taken. Where relevant, information about any behavioural issues was highlighted along with behaviours that indicated if the person was having a 'good' day or 'bad' day. This meant people were supported appropriately by staff who were sufficiently informed about people's personalised behaviours and moods.

The premises were adapted to the needs of the people living at the home. There was a lovely aspect looking out to sea and people told us they enjoyed spending time in the garden which overlooked the beach, during the warmer months of the year. Internally the home had been equipped with hand rails to help people move around the home independently and safely. There was a stair lift available for those people who resided on the middle floor of the home, who may need assistance when moving upstairs. The manager told us that most people living at the home had some form of cognitive impairment or memory issues, although we observed their mental health needs were not complex. We discussed dementia care best practice guidance with the manager and the potential of adapting the environment to improve support for people living with dementia, as their needs changed.

Good

Is the service caring?

Our findings

People described staff as "very nice people", "helpful" and "perfect." One person said, "I couldn't find fault with any of them they are great." Another person told us, "The staff are very kind." Other comments included, "The staff are very nice people", "They are all really nice with me" and "Oh, staff are good."

We observed interactions between staff and people that were polite, considerate and caring. Staff used terms of localised language such as "love" and "pet" and people appeared both happy and comfortable with this. They gently encouraged people when they moved about the home saying statements such as, "It's just down here X (person), there you go." Staff said "You are welcome" when people thanked them for their care and support. People were asked if they were finished with their meals and they were given reassurance by staff where they displayed disappointment at not finishing all of the food they had been given. Staff sang with people in the lounge and there was a good atmosphere where staff and people shared jokes and enjoyed camaraderie. Relationships between staff and the people living at the home were positive.

Relatives told us that they were kept informed and felt included in their relation's care. In relation to their activities of daily living, such as eating and partaking in activities, we observed people were kept informed by staff and involved in decision making around, for example, what activities were on offer, how they spent their time and where they ate their meals. Explanations were given by staff when they assisted them with their needs. One relative said, "Staff don't tell people or force them to go anywhere or do anything. They explain, ask and encourage people. This meant people were respected and empowered to partake in their own care.

People were given encouragement to be independent and staff explained how they promoted this. One member of staff said, "I let people do as much as they can for themselves and encourage them. Some people can wash themselves and we try and encourage them to do this." Another member of staff told us, "The whole object is to keep people independent." We observed people had mobility aids which they used to move around the home freely and independently. Where people were unsteady on their feet at times, even when using walking aids, staff walked behind them in case they fell backwards. This showed that staff promoted people's independence to walk around themselves as much as possible, and we saw that they only provided physical support if necessary.

Privacy was promoted within the service and we saw that one person who had a visitor was able to enjoy private time with them in a separate communal area where the door could be closed. One relative told us, "If we come in and X (person) is in the conservatory the staff gently encourage other people to move to another area so that we can have some privacy, or we could go to their room." People were treated with respect and their dignity was promoted. Each person appeared well presented and records showed they were regularly supported with their personal care. Staff gave us examples of how they promoted people's privacy and dignity, including leaving them in private when using the bathroom, as long as they were not at risk of injuring themselves. This meant people were treated with dignity and respect.

Diversity was promoted within the service and some people were supported to attend local church services

on a weekly basis and religious services and blessings were also offered by visiting ministers in the home. The manager told us that no people had formal advocacy arrangements in place but that if this was needed it would be arranged through the local authority and people's care managers.

Good

Is the service responsive?

Our findings

People told us they received all of the care and support they needed and whatever they needed, staff accommodated. One person said, "If you need help they (staff) help you." Another person told us, "I get up in the morning. They (staff) help if I need a shower." A third person commented, "I am very well looked after in here. It is lovely."

Staff displayed knowledge of individual people and their specific care needs and told us how they supported them. The information they provided tallied with information within the person's care records. This showed staff knew people well and were confident about how to respond to their needs. Care was person centred and people's care records were individualised. Staff told us about people's likes, dislikes and their personal preferences. Care records were reviewed regularly and updated when people's needs changed. They contained personalised information about how to support each individual, such as their preferred night time routines and activities they liked to engage in. There was information about what was important to the individual and who was important in their lives.

Preadmission assessments were carried out before the person started using the service and on-going monitoring of people's health and wellbeing was carried out. Care plans were in place for specific needs such as diabetes care, skin integrity management and nutritional needs. There was evidence that responsive action was taken where people needed input into their care from, for example, GP's or dieticians. One person was found to have swelling on their body and this had been fully investigated and a referral made for further tests to be carried out. Where people's behaviours had changed monitoring was put in place and where people had indicated they were in pain this was monitored and actions taken recorded in daily notes. This meant people were supported to maintain their health and wellbeing.

People had choices about how they spent their time, what activities they pursued and food. Some people, who were able, entered the community regularly alone and this had been appropriately risk assessed. We saw people being asked what they wanted to do during the afternoon, whether they wanted their dinner in the dining room and whether they wanted to watch a film. Staff told us they promoted choice and our findings evidenced they did. Activities such as general knowledge quizzes were organised by the manager and staff to stimulate people and keep them occupied. This showed the provider promoted social inclusion and provided stimulation to those people who were either not willing or able to leave the home.

Staff told us that they had not needed to assist anyone to make a complaint about the service and people told us they had not had reason to complain. One person told us, "There is nothing that I would need to complain about."

Emergency healthcare plans were in place should people need to be transferred to a hospital setting in an emergency. This meant there was information available for accepting facilities, should people need to transition between services at short notice.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a manager in post who had been registered with the Commission since October 2010 to manage the delivery of the regulated activity at this service. The provider was present during the two days that we visited the home and staff told us they were actively involved in the service and visited regularly.

Staff reported an open culture and said they would feel comfortable with approaching either the manager or provider with any issues they may have. They said that leadership within the service was good and they were informed of all key information in a timely manner. One member of staff said, "X (the manager) is brilliant. You can go to her with anything." Some of the staff we spoke with gave examples of where they had been supported by the manager during times of difficulty in their personal lives and told us they had appreciated this support.

People described good leadership and said the provider and manager looked after them well. They gave positive feedback about the manager and one person commented, "X (provider) checks that everyone is alright every morning they come in". This meant the provider was actively involved in the service and sought to ensure people were well looked after.

The provider told us they wanted to provide people with a service which met their needs well and was 'like home'. People told us they enjoyed living at Beachville and the provider and manager told us they got great satisfaction in providing a service which people enjoyed and for which they received good acclaim from both people and their relatives.

The provider had systems in place to monitor the service but these were limited. They included medicines audits which were carried out regularly and accident and incident monitoring and analysis. Each accident or incident had attached information about what had happened, who was involved, what the issues were and any actions taken. The manager and staff told us that medicines were audited thoroughly, although medicines audit records could be more detailed. People's care records were reviewed regularly and we found they were relevant and up to date. Infection control audits were not carried out, however, we found no issues with cleanliness or the prevention and control of infection within the home.

With the exception of the issues we found related to environmental risks within the premises (identified in the 'Safe' section of this report), health and safety checks and fire safety checks were carried out regularly. The provider had not identified these environmental risks themselves due to a lack of quality monitoring, but once brought to their attention, plans were put in place to rectify these shortfalls within 48 hours. We discussed this with the provider and manager who informed us that a review of health and safety monitoring would take place and they said they would ensure that systems were developed which were capable of identifying any future oversights.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

The manager told us they enjoyed good working relationships with external healthcare professionals and other relevant organisations. Records confirmed that where the provider or manager sought input into the service from external parties, this support was promptly provided.

Staff meetings were not scheduled, but staff told us they did not feel the lack of meetings was a problem. Staff confirmed they received regular supervisions and one to one sessions with the manager every time there was information to share. The manager told us that they obtained people's feedback by engaging with them regularly and asking them questions about their care and their feelings about living at the home, in order to address any concerns or issues they may have. This meant the provider involved and included them in the service, obtaining their views to drive forward improvements.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against environmental risks associated with the premises as these had not been appropriately assessed and mitigated against. Regulation 12 (2)(b)(d)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to ensure that environmental risks within the home were addressed and auditing was not thorough. Regulation 17(1)(2)(a)(b).