Larchwood Care Homes (North) Limited

The Chanters

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 10 May 2016. At the last inspection on 28 May 2014, we found the service to be compliant with all regulations we assessed at that time.

The Chanters is a purpose built care home, owned and operated by Larchwood Care Homes (North) Limited. The service is registered with the Care Quality Commission (CQC) to provide personal care and accommodation to a maximum of 40 people. Accommodation is provided over two floors and there is lift access. The home is located near to the town centre of Atherton in Wigan, Greater Manchester. Car Parking facilities are available at the front and large gardens are located at the rear of the property.

During this inspection we found one breach of the Health & Social Care Act (Regulated Activities) Regulations 2014. This was because some aspects of the environment did not take account of national best practice and were not being used for the intended purpose. You can see what action we told the provider to take at the back of the full version of the report

We asked people who used the service if they felt safe and they told us they did. We looked to see how the service sought to protect people from abuse and found there were appropriate safeguarding and whistleblowing policies and procedures in place. All the staff we spoke with demonstrated they had a good understanding of the types of abuse and the procedure to follow if they suspected that a person was at risk of, or was being abused.

We asked staff about whistleblowing. All of the staff we spoke with told us they would not hesitate to use the policy and identified internal reporting protocols. Staff also referred to CQC as an external agency they could contact.

We observed a senior member of staff on a medicines round and found peoples' medicines were given safely and as prescribed. We found safe systems were in place for ordering, storage and disposal of medicines.

Staff induction was robust and included mandatory training, shadowing and access to appropriate policies and procedures. Further training was on-going and staff were encouraged to access training as part of their on-going development.

We looked at care plans to establish that people were receiving the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. We found that the care files were large and contained historical information that was no longer reflective of the person's needs and this made eliciting the current clinical picture difficult. We spoke with the registered manager about this who informed us that a programme of streamlining the files was underway in conjunction with transferring the documentation to the new provider's format.

We looked in detail at the care records of people living with complex needs. For example, people at a higher risk due to poor nutrition, falls or pressure care. We found that people's risks were appropriately assessed and managed and that care plans had been updated to reflect people's changing needs in a timely way.

People who used the service said the food was good and we saw that there was plenty choice. However, we found that people who used the service who were living with a diagnosis of dementia could have been better supported at mealtimes through the use of a pictorial menu. This would help people living with dementia to better understand the food options being presented to them.

During our inspection visit we asked the registered manager whether or not the service worked to a nationally recognised model of dementia care and we were told they did not. We found that some aspects of the service had been improved to enable people who might be confused to orientate themselves but overall the service was not sufficiently dementia friendly.

We looked at the communal areas of the upper floor and found the décor to be worn in parts and traditional in presentation. Storage space on this floor appeared to be limited and we found communal rooms intended for the use of people who used the service being partially used as storage areas. For example, the room used as a hair salon contained filing cabinets and a small communal lounge appeared to be used to store various miscellaneous items. We spoke with the registered manager about this who acknowledged that some areas of the home were not fully utilised in line with their intended purpose and that aesthetic improvements could be made to the upper floor.

The service worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a good working knowledge of capacity issues and DoLS.

People who used the service and their relatives felt staff were kind and caring. We observed care and support being delivered during the day and saw that there was a friendly and relaxed atmosphere and interactions between staff and people who used the service were pleasant. Consent was sought for all interventions offered.

Some people were being cared for were nearing the end of their lives and families told us they were impressed by the kindness and compassion of the staff and the home's commitment to ensuring people's end of life wishes were respected.

Care and support plans contained person-centred information which detailed people's likes, dislikes, personal preferences and life and social history. We saw that people who used the service, or their lawful representatives, had been involved in planning and agreeing care.

There was a complaints policy and associated procedure and information about how to make a complaint was available in people's own rooms and at the entrance to the building. People told us they had no complaints, but were confident any concerns would be dealt with promptly.

The registered manager was very visible within the home and actively involved in the provision of care and support. Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff.

Audit and quality assurance was completed on a regular basis and covered a wide range of topics. We saw that where internal audits had identified issues, action was taken and lessons learnt.

Staff were able to approach the management at any time for support and assistance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

We asked people who used the service if they felt safe and they told us they
did.

The service had an up to date and relevant safeguarding policy and
procedure and staff demonstrated a good working knowledge of the
procedures.

The service had a robust recruitment procedure and staffing levels were
sufficient to meet the needs of the people who used the service.

Medicines were administered safely and as prescribed.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

The service did not work to a nationally recognised model of dementia care and areas of the service were not being used for their intended purpose.

Staff induction was robust and further training was on-going and staff
were encouraged to access training.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives felt staff were kind and caring.

We observed care & support being delivered during the day and saw there was a friendly and comfortable atmosphere and interactions between staff and people who used the service were pleasant. Consent was sought for all interventions offered.

Is the service responsive?

Good

Care plans were person centred and detailed people's likes, dislikes and personal preferences.

There was an appropriate, up to date complaints policy. People told us they had no complaints, but were confident any concerns would be dealt with
promptly.

People who used the service were supported to participate in activities.

Is the service well-led?

Good

The service was well-led.

People we spoke with all thought the service was well-led.

Audit and quality assurance was completed on a regular basis and covered a wide range of topics.

Information was shared with people who used the service and their relatives and we saw resident & relatives meetings took place.

The Chanters

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.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information we held about the home in the form of notifications received from the service; including safeguarding incidents, deaths and injuries.

During this inspection visit, we spoke with the following people: 16 people who used the service; four visiting relatives; the registered manager; the care manager; four care assistants; a housekeeper; the cook; and one visiting healthcare professional.

We looked in detail at the following documentation: 10 care plans and associated documentation; six staff files, including recruitment & selection records; a variety of training & development records; audit & quality assurance; policies & procedures; and safety & maintenance certificates.

Good

Is the service safe?

Our findings

People we spoke with told us they thought The Chanters was safe. Comments from people living at the home and their visiting relatives included: "I feel very safe. I'm looked after very well; I can't think of anything I need." "I've only come in for a few weeks to get back on my feet but I feel very safe, no problems." "The staff come quite quickly if I press my buzzer when I need help. They are very caring here." "I can relax because I know [relative] is safe and well cared for by the staff who are just lovely." "I think my [relative] is safe here, I come most days and never had any concerns."

We looked at staffing levels and found that during the day a maximum of six staff would be on duty providing direct care and support; they were supported by housekeeping, maintenance and catering staff. At night, a maximum of four carers would be on duty. We asked the manager how staffing levels were determined and whether a dependency tool was used. We were told staffing levels were historical and not calculated based on peoples' dependency levels. However, we were told that deployment of staff was flexible to meet peoples' individual needs. Throughout the inspection we saw sufficient numbers of staff were on duty to meet peoples' needs. We also looked at historical and planned rota's and found staffing levels to be consistent.

We looked to see how the service sought to protect people from abuse and found there were appropriate safeguarding and whistleblowing policies and procedures in place. Staff were able to describe the homes alert process and the local authority protocols. All the staff spoken with demonstrated that they had a good understanding of the types of abuse and the procedure to follow if they suspected that a person was at risk of or was being abused.

We asked staff about whistleblowing. All of the staff we spoke with told us they would not hesitate to use the policy and identified internal reporting protocols. For example informing head office if they did not feel their concerns were being taken seriously. Staff also referred to CQC as an external agency they could contact.

On the day of our inspection we looked at the care records for 10 people. We did this to establish if people were receiving the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. We found that the care files were large and contained historical information that was no longer reflective of the person's needs and this made eliciting the current clinical picture difficult. We fed this back to the registered manager who informed us that a programme of streamlining the files was underway in conjunction with transferring the documentation to the new provider's format. We case tracked five people with complex needs that had presenting high risk areas. For example, nutrition, falls and pressure care. We found that people's risks were appropriately assessed and managed and that care plans had been updated to reflect people's changing needs in a timely way.

We saw that accident & incident reports were completed by staff in a timely manner and appropriate action taken. We saw people's individual risk assessments were comprehensive and actions taken were identified to mitigate the risk of future re-occurrence. For example, we saw a person that had two falls in the same day. Medical attention had been sought and the falls risk assessment and care plan had been updated. We

ascertained that the person's GP had been contacted following the falls and a referral to the falls clinic had been requested. A pressure mat transmitter was also in place next to the person's bed. This would raise an alarm when the person got out of bed and alert staff so they could respond and support the person when mobilising which would help to reduce the risk of the person having a further fall.

Risk assessments included people's health needs. People's allergies were easy to identify and risks of malnutrition were covered. We saw that detailed guidance of how to manage risks were outlined and reviewed. Staff were knowledgeable about people's health needs and the associated guidance. This showed that possible risks to people were identified and managed appropriately.

We checked that people who used the service were receiving their medicines safely and as prescribed. The registered manager showed us that they had recently updated the medication records to include: Topical cream charts, new codes for staff to follow if the person didn't take their medication, allergies and PRN protocols. We ascertained that the new records were being implemented in line with the peoples' prescriptions and commencement of the new medication administration record (MAR).

We looked at medicine administration records and availability of medicines for seven people. We saw people's allergies were consistently documented in the medication file and the person's care records.

We observed medicines being administered and spoke with the two senior care staff. We found all the staff responsible for administering medication had received training and we saw there was always a trained member of staff on duty to administer medicines. Staff administering medication had annual medication training and competency assessments were undertaken.

We saw the MAR was kept in a folder for each person which displayed a picture of the person. The medication was in blister packs and stored with the folder in a locked trolley in a locked room. We saw all the MAR had been completed correctly and there were no omissions of the staff signatures.

Medicines were organised and there was a sufficient supply of medication available to ensure people received their medicines as prescribed. We found medicines were administered correctly but there was some discrepancy amongst staff regarding documentation and the record for a person that refused medication.

We saw there were no cream charts in place to inform staff regarding the application of creams. However, we spoke to a person prescribed creams and ascertained that the cream had been applied consistently and as per directed by the GP. The registered manager had already identified these issues through their own internal auditing process and was able to demonstrate that the gaps noted were being addressed and the timescale in which the new system would be operational.

We looked at recruitment procedures and found robust and safe recruitment practices were in place. This was evidenced through our examination of employment application forms, job descriptions, employee's proof of identity, written references and training certificates. Disclosure and Barring Service (DBS) checks had also been completed to ensure the applicant's suitability to work with vulnerable people.

Health & safety and building maintenance records were examined and found to be in order. Up to date certificates and checks had been completed in respect of gas and electrical safety, fire safety, hot water temperate and portable electrical appliances. However, at the time of our inspection checks in relation to waterborne viruses were out of date. Upper floor windows were compliant with safety regulations and suitable window restrictors were place. Equipment used for moving & handling people had been serviced

and maintained in line with regulations.

We looked at how well people were protected by the prevention and control of infection. We found the service had been working with the local authority infection prevention and control (IPC) team and scored highly in a recent audit. At the time of our inspection the service was found to be visibly clean. However, during the morning of our visit there was a strong odour on the ground floor. We spoke with the housekeeping staff about this and we were told that carpets were cleaned on a regular basis but that it was an on-going challenge to keep on top of the odour.

Requires Improvement

Is the service effective?

Our findings

Before our inspection visit we looked at various sources of information to help us understand the nature of the service provided at The Chanters. We looked at the provider's corporate website and saw the type of care and support advertised as being provided at The Chanters was 'specialist dementia care'. Therefore during our inspection visit, we asked the registered manager whether or not the service worked to a specific dementia model and we were told they did not.

During our inspection we observed that doll therapy was being used to provide comfort and support to people living with a diagnosis of dementia. However, whilst it was evident these people benefited from this kind of comforter, we established the dolls had been provided by the relatives of the people who used the service, and not as part of a formal therapeutic programme. Additionally, whilst some aspects of the environment had been improved to enable people who might be confused to orientate themselves, the overall environment was not sufficiently 'dementia friendly'.

We also looked at the communal areas on the upper floor and found the décor to be worn in parts and traditional in presentation. Storage space on this floor appeared to be limited and we found communal rooms intended to be used by people who used the service, were partially used as storage areas. For example, the room used as a hair salon contained filing cabinets and a small communal lounge appeared to be used to store various miscellaneous items. We spoke with the registered manager about this who acknowledged that some areas of the home were not fully utilised in line with their intended purpose and that aesthetic improvements could be made to the upper floor.

This was a breach of Regulation 15(1)(c) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to premises & equipment.

We looked at induction and training & professional development staff received to ensure they were fully supported and qualified to undertake their roles. We looked at eight staff files and saw that staff recruited recently had undertaken an induction programme and completed mandatory training. New staff were given the opportunity to shadow more experienced colleagues before working unsupervised and were also required to complete a formal probationary period.

Comments from staff we spoke with included: "We have enough training and supported to do extra training. I've done a higher level NVQ and asked for further dementia training which I'm confident will be supported. We have regular supervision and an appraisal every 12 months. I feel very supported in the role." "We have a lot of training but it's mostly all e-learning and I personally don't feel that you achieve as much with e-learning." "Training is OK, we do go on courses and it's a mixture of some face to face training and some e-learning."

We saw the training matrix which demonstrated staff had completed, or were scheduled to complete, a range of training courses. These included first aid, health & safety, medication, moving & handling, safeguarding and dementia awareness. At the time of our inspection visit 86% of staff had completed their

mandatory training modules.

Supervision sessions were completed on a regular basis and appropriate records were maintained. We saw that discussions had taken place around training, professional development and day to day operational matters. Annual appraisals were completed and records maintained.

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

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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager demonstrated effective systems to manage DoLS and mental capacity assessments had been consistently completed with people to determine whether they had capacity to make specific decisions. In instances where people were deemed not to have capacity, the registered manager had completed standard authorisations which had been submitted to the local authority. There was a current policy in place detailing procedures.

The registered manager explained that they had maintained an electronic matrix to manage DoLS but that this had been erased by the providers corporate IT department when the system had changed. We saw the registered manager had transferred the information in the interim to a paper document to maintain oversight and was in the process of redoing an electronic record. The registered manager was also able to show us the authorisations in people's files. The registered manager was able to demonstrate that they had maintained oversight of the authorisation's submitted and granted despite the working matrix having been destroyed.

Staff were able to discuss the relevance of DoLS and the requirement to apply the least restrictive approach. We saw mental capacity assessments and restrictive screening tools had been completed. Assessments were decision specific and care plans where reflective of this. We saw a person that displayed challenging behaviour had care plans in place detailing how this was managed by least restrictive methods.

We saw people's consent had been obtained to receive care and treatment. People who were able had signed consent forms and we observed staff asking people for consent throughout the inspection. For example, we heard staff obtain consent before supporting people with medication.

During our inspection we looked at the mealtime experience at The Chanters. People we spoke with across each of the two floors told us they were happy with the quality of the food. Comments included: "I can have meals in my room if I want. They give me what I like to eat." "The food is glorious, you will never go hungry here." "The food is good my [relative] is always offered an alternative if my [relative] wants something else." "Very good meals, they know what I like."

During lunch time service on the ground floor unit, we completed a 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 saw that people were given a choice of where to have their lunch, either in their own room or in the dining area. We saw that people were offered a choice of hot or cold drinks and that staff took their time to ensure people were served the choice of meal they wanted. However, due to the nature of the service provided on the ground floor unit, people who used the service may have benefited from the

option of having a pictorial food & drink menu. This type of aide can help people who are living with dementia to communicate their personal preferences at mealtimes.

Good

Is the service caring?

Our findings

Without exception, people we spoke with told us they thought The Chanters was caring. Comments from people living at the home and their visiting relatives included: "The staff are wonderful and very caring." "The staff never rush me, they take their time with me and are very patient." "All of the staff are caring, they look after me well, I've definitely no complaints." "The quality of care is excellent. I can't praise the staff enough. The staff have a genuine interest in residents lives and share their own lives with residents by talking about their own families. When I take [relative] out for the day they always have my [relatives] room and night things ready for when we come back. It's like I'm bringing [relative] home. They ask about my [relatives] day and what my [relative] did. They genuinely care." A visiting healthcare professional we spoke with commented: "The general consensus amongst the team is that this is a good home. The staff are knowledgeable and caring."

We looked to see how the service promoted the principles of equality & inclusion and how people's human rights were protected. We found the service aimed to embed these principles through effective support planning to enable people to make choices for themselves. We found documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed which met their individual needs.

Staff we spoke with also demonstrated a good working knowledge of these principles when supporting people in a care environment. For example, staff we spoke with told us: "I always knock on people's doors before going in. When people leave their bedrooms I make sure they are appropriately dressed. When supporting people with personal care, I make sure bathrooms are locked and cover people with a towel so they don't feel exposed." "I don't take peoples' abilities away. There is a person living here that likes the crust cut off the toast. I give them the knife so that they can do it for themselves. Do the things for people that they can't do for themselves – not what they can" "Including people isn't about treating everyone the same, it's about respecting people's differences and their personal preferences."

We looked at The Chanters approach to end of life care (EoLC) and found the home was not engaged with the 'Six Steps' EoLC Programme. This is the North West End of Life Programme for Care Homes and is co-ordinated by local NHS services. However, we saw the home had a good working relationship with the local district nursing service and that the physical, emotional and spiritual needs of people nearing the end of their lives were being met. We spoke with a visiting relative whose close relation was nearing the end of their life and we were told: "When we were told that [relative] nearing end of life, we wanted [relative] to stay in hospital. We were persuaded to let [relative] come back here and we are glad we did. [Relative] settled as soon as we arrived back in [relatives] own room. The staff have been so supportive, they have offered us a bed so we can sleep here if we want. We picked this home in the first place because of the atmosphere and the staff"

During our inspection, one person who used the service showed us their bedroom. We found their room to be personalised with individual items and was homely and welcoming. We observed staff being respectful of people's private spaces whilst maintaining a supportive and caring presence within the home.

Good

Is the service responsive?

Our findings

People we spoke with thought The Chanters was responsive to their needs. Comments included: "My carer takes me out to the bowling green and the pub were I can have a couple of pints." "Some people go in the garden, I don't like going in the garden, they don't make me if I don't want too." "I please myself what I do, I'm my own boss. I like it here, they look after you. They just arranged for me to have new glasses." "They always come and help me if I need it. I'm only here for two weeks and I'm more contented now than when I came in." "The activities are excellent particularly the virtual cruises."

Spoke we spoke with demonstrated a good understanding of how people's needs were met. Comments included: "I keep a record of what the residents like. I speak to all the residents regularly about the menu. You can't please everybody all the time but we try. I bake an individual cake with their name on it, for each resident on their birthday. We like to make it a special day." "We assess people and make sure that we can meet the person's needs before we would offer a place. The assessments are in a file which we take and work through. It takes a few hours to complete an initial assessment. We then develop a short term care plan." "We do an initial assessment to establish the person's needs and to see if we can meet them. We show the person photographs of the home if they are unable to visit. We get the medical, social history and complete a mental capacity assessment." "I love interacting with the residents and getting to know them. We are encouraged to do it. All the staff are one big happy team." "We get involved with the entertainment, dressing up in old clothing and the like, I even come in on my day off"

At the time of our inspection visit the activities co-ordinator had recently left the service. However, we saw that a new activities co-ordinator had been recruited and was awaiting a start date. In the intervening period we saw that care staff would still encourage people who used the service to participate in both group and one to one activities. We also saw how an external agency was used by the service to enable people to go out on a regular basis as part of a structured activity. This was used to good effect to support people with a DoLS, as regular activities outside of the service helped to lower people's levels of agitation.

We looked at pictorial evidence of activities that had recently taken place and saw that people who used the service had enjoyed a 'virtual cruise'. People would be asked where in the world they would like to visit and the staff would help them organise a themed event based on their chosen 'virtual destination'. We saw that staff would dress up in costumes and decorate the communal areas with large photographic travel posters obtained from local travel agents. The catering staff would also provide a menu of appropriate food and drink for the chosen destination which included the Caribbean, Italy and Blackpool. Without exception, people we spoke with commented how much they enjoyed participating in this type of event.

We looked at the care and support plans of 10 people who used the service and we found care records contained person-centred information which detailed people's likes, dislikes, personal preferences and life and social history. We also saw that people who used the service, or their lawful representatives, had been involved in planning and agreeing care.

We looked at how the service managed complaints and saw a complaints policy and associated procedures

were in place. The policy clearly explained the process people could follow if they were unhappy with any aspect of the service. Information about to raise a concern was also contained within a 'welcome pack' which was placed in peoples' rooms. We looked at the complaints log and found the service had a low level of complaints; complaints that had been made we seen to have been dealt with in a timely manner.

Good

Is the service well-led?

Our findings

There was a registered manager at the home. 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.

Before the inspection, the registered manager had completed a Provider Information Return (PIR) and sent this back to CQC when asked to do so. This is a form that asks the provider to give some key information about what the service does well and improvements they plan to make.

People we spoke with all thought The Chanters was well-led. Comments from people who used the service and their visiting relatives included: "The manager is lovely and very approachable." "I've only needed to complain once and the issue was dealt with by the manager very quickly." "I think the home is very well-led and have no issues about that."

Comments from staff we spoke with included: "The registered manager is lovely. Approachable, supportive and caring." "We have huddle meetings monthly where we discuss things." "The registered manager is lovely. Really helpful, accommodating and flexible." "The managers care about us too. It's a genuine helpfulness and they have provided me a lot of support that I'm very grateful for."

We saw that the registered manager was very visible within the home and actively involved in the provision of care and support. Throughout the course of the inspection we saw the registered manager walking around the home, observing and supporting staff.

We saw the service had well established links with the local NHS community liaison teams, district nurses, the pharmacy and G.P's, who all supported people who used the service.

We looked at how information was shared with people who used the service and their relatives and we saw that resident & relatives meetings took place. This was evidenced through minutes of meetings being recorded. We could see that a variety of topics where discussed during these meetings and that people were able to share their views and experiences. We also saw that 'relatives opinion surveys' were made available in the entrance hall of the service. However, limited information was available during the inspection to demonstrate how such surveys had been analysed and any positive impact.

Audit and quality assurance was completed on a regular basis and covered a wide range of topics. We saw that where internal audits had identified issues, action was taken and lessons learnt.

We saw that staff meetings were held on a regular basis and appropriate records were maintained. Staff told us they were able to contribute to agenda items and that staff meetings were useful and productive.

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 15 HSCA RA Regulations 2014 Premises and equipment Aspects of the premises and environment did not sufficiently take into account national best practice and were not being used for the intended purpose due to insufficient storage.