Four Seasons (Bamford) Limited

The Heights Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Heights is a residential care home providing personal and nursing care for up to 36 people, with a range of medical and age-related conditions, including arthritis, frailty, mobility issues, diabetes and dementia. The service is divided over two floors. On the day of our inspection there were 29 people using the service; 14 people were on the ground floor and 15 on the first floor.

People's experience of using this service and what we found

We have found evidence that the provider needs to make improvement across all areas. Please see the information in the sections of this full report.

We found people were at significant risk of harm from inadequate staffing levels. We received overwhelming feedback from people using the service, staff and relatives that there were not enough staff deployed to meet people's identified care and support needs in a safe and consistent manner. Staff were unable to ensure people's safety and welfare. Care plans contained evidence, in the daily notes, of the potential risk to individuals and the frustration of staff at the impact of inadequate staffing levels. Staff told us they did not have enough time to read care plans. They said they relied upon discussions with other staff and staff handovers. This has resulted in people not receiving the consistent care and support they required. There was not enough staff deployed to ensure people's safety in the event of a fire and there was a lack of effective contingency measures in place to cover short notice staff absences. This placed people at risk of potential harm. Where accidents or incidents had occurred, lessons were not always learned to prevent the same thing happening again.
Medicines were stored, administered and disposed of safely by staff who were trained to do so. Systems and processes were in place to safeguard people from abuse. Staff understood the signs of potential abuse and how to respond appropriately.

We found people were at risk of dehydration. Food and fluid records did not indicate people had been provided with enough to drink. There was no documentary evidence of actions to be taken when fluid intake had been recorded as being very low. Staff did not always have the necessary training to meet people's needs. Guidelines for staff followed best practice guidance and some staff had said they had received training, but this was inconsistent. We have made a recommendation with regard to the training.
People were not provided with adequate levels of personal care. Staff told us they did not always have time to support people with their personal hygiene. Furthermore, several records showed people had not been provided with assistance with oral care. Infection prevention and control measures were in place but not always adhered to and the premises were not clean in all areas.
People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff did not always have time to spend with people which impacted on their caring approach, we did see kind, friendly and respectful examples of caring on the day. People were not provided with adequate levels of personal care. Staff told us they did not always have time to support people with their personal hygiene. Furthermore, several records showed people had not been provided with assistance with oral care.

Quality assurance systems were not consistently effective. The registered manager had not completed regular audits and quality assurance monitoring.
Despite concerns being highlighted and regularly brought to the attention of the registered manager, there had been no change and no improvement. This had resulted in a culture of despondency and frustration amongst staff, who told us they felt they were not listened to, supported or valued.

Rating at last inspection
Rated as Good, report published 3 February 2017.

Why we inspected
This was a scheduled inspection based on the rating at the last inspection.

Enforcement
We have identified breaches in relation to person centred care, safe care and treatment, staffing and leadership at this inspection. The provider took immediate action to mitigate the most serious risks we identified on our inspection. You can see the action we have asked the provider to take at the end of this full report.

Follow up
Immediately after our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk. Additional resources were also immediately deployed to the service from other areas of the providers network. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Heights Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by three inspectors 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.

Service and service type
The Heights 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced and took place on 23 and 31 July 2019.

What we did
Prior to the inspection we reviewed all the information we held about the service including notifications received by the Commission. A notification is information about important events which the service is required to tell us about by law. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with six people who lived at the service and two visiting relatives. We observed staff interactions with people. We spoke with five care staff, two nurses, the activities co-ordinator, one member of the domestic staff and a visiting health care professional. We also spoke with the registered manager, the acting head of quality; the resident experience team manager, the regional manager; the managing director and the chief operating officer.

We looked at documentation related to the running of the service, including four people's care and support plans, risk assessments and progress records. We also looked at records of accidents, incidents, complaints and compliments, medicine records and staff files, including training and recruitment.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to Requires Improvement. Some regulations were not met. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- People were at risk of harm from inadequate staffing levels. On the first day of our inspection, we received overwhelming feedback from people who used the service, relatives and staff that there were not enough staff deployed to meet people's identified care and support needs in a safe and consistent manner.
- People did not always receive the safe and effective care and support they needed in a timely way. We observed that staff were allocated people to support and this was often required to be completed in twos. This meant there were frequently times when there were no other care staff in the communal areas to observe people, many of whom were at risk of falling when left unattended. A member of staff told us, "We have to leave people in the lounges, it's not safe. Anything could happen."
- There were insufficient contingency measures to cover short notice absence, which placed people at risk of harm. Staff told us about times when other staff had called in sick and the on-call manager was unable to cover the shift. This was confirmed by staffing rotas. This meant people did not get their care as planned as there was a delay due to lack of available staffing.
- Insufficient staffing levels meant staff were unable to ensure people's safety and welfare. One person's care plan contained evidence in the daily notes, of the potential risk to the individual and the frustration of staff at the impact of inadequate staffing levels. This included the following statement; 'Staff had found it very difficult to meet [name] needs and the needs of other residents today, as we are not staffed enough to give one-to-one care, which is what [name] needs to keep them safe from falling and injuring themselves.' This placed them at risk of harm.
- Staff told us they did not have enough time to read care plans. They said they relied upon learning from colleagues and staff handovers. This has resulted in the risk of people not getting the required support to ensure their safety and wellbeing.
- There were not enough staff deployed to ensure people's safety in the event of a fire. Personal emergency evacuation plans (PEEPs) lacked detail about how staff should respond in the event of a fire, given the low staffing levels. This placed people and staff at risk of harm. A member of staff told us they were very concerned about what would happen if there was a fire.

The lack of an effective system to determine safe staffing levels placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we wrote to the provider and asked them to take urgent action to ensure there were enough staff to ensure people's safety. On the second day of inspection we observed that the provider had increased staffing levels which had a positive impact on people's safety. They also advised us they had reviewed contingency plans for short notice staff absence and addressed the procedures in place for safe

evacuation in the event of a fire.

● People were supported by staff who were fit and safe to support them. Before staff were employed, the provider carried out checks to determine if staff were of good character and requested criminal records checks. These checks are to assist employers in maker safer recruitment decisions.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection
● Opportunities to learn from accidents and incidents had been missed. Records showed people had fallen when unsupervised in communal areas, this was due to there being insufficient staff to support them. Despite this, action had not been taken to ensure staff were deployed to ensure people's safety and we observed people were left unattended and at risk during our inspection. This demonstrated that lessons had not been learned to protect people from injury.
● Risks to individuals were recognised, however staff did not have time to read plans about how to manage the risks fully.
● Infection prevention and control measures were in place, but not always adhered to and the premises were not clean in all areas.
● We saw several areas, including staircases which were unclean and rooms which were dirty and carpets which were stained. Staff told us, and records showed; there had been no domestic staff on duty for the previous four days, as they had been covering the laundry room. This had a negative impact on the cleanliness of the service and increased the risk of infection spreading.
● Some equipment used in people's care and support was not well maintained, which increased the risk of infection. For example, the covering of an adapted chair had worn away which meant it could not be affectively cleaned. Staff told us these chairs were shared between people, this increased the risk of infection.

We found no evidence that people had been harmed. However, there was a failure to safely manage risk and take steps to prevent and control the spread of infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we wrote to the provider. The provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk. Resources were provided to support the registered manager with increased monitoring and action planning and daily walkabout audits were to be held.

Using medicines safely
● People were supported by staff to take their medicines at the right time.
● Medicines were stored securely, and staff were trained and monitored to ensure they followed safe practice.
● There were clear guidelines when people needed 'as required medicines' and medicines were reviewed with health professionals, to ensure they remained suitable for people to have.

Systems and processes to safeguard people from the risk of abuse
● People were supported by staff who recognised the signs of potential abuse.
● Staff had a good knowledge of how to recognise the signs that a person may be at risk of harm and knew how to raise these concerns.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- There was a risk people may not have enough to drink. Records did not evidence that people were offered enough to drink, this put them at risk of dehydration. Where records showed people had only drunk a very small amount, there was no evidence that action was taken to address this.
- People were at risk of weight loss. Records to monitor people's weight were inconsistent and some people had no recent weight recorded so staff could not identify if there were any concerns. Where it had been identified that people had lost weight, advice had been sought from health professionals, however this had not been incorporated into care plans which placed people at risk of inconsistent support that did not meet their needs. For example, one person had lost weight. The dietician had advised staff to offer frequent snacks. There was no evidence of this in food records for this person and they had continued to lose weight.
- Nationally recognised tools were used to assess risk, but they were not always used effectively. For example, although a nationally recognised tool was used to assess the risk of malnutrition, appropriate action, had not always been taken when risk was identified, and people's expected outcomes were not always clearly identified, or reviewed on a regular basis.

The provider failed to ensure risks associated with eating, drinking and weight loss were managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Overall, mealtimes were positive, sociable experiences. However, we saw some people who needed assistance to eat and drink, waited for long periods for assistance from staff.

Staff support: induction, training, skills and experience

- Staff did not always have the training they needed to meet people's individual needs. Staff training records showed staff had training in key areas such as moving and handling and medicines management. However, staff had not always received training in relation to people's specific needs. For example, several people had learning disabilities or mental health conditions. However, records showed and staff told us, they did not have any training in these areas.
- Some staff expressed concern that the training offered was mainly completed on line. They told us this did not support their learning needs, and they did not feel it was effective.
- Staff did not always receive an effective induction to their role. A recent recruited member of staff told us

they had some basic training and a couple of shadowing shifts. They had not been asked to read any care plans and had not done so. Consequently, they had learnt about people's needs from other staff. Other staff commented that new staff were 'not properly prepared' for the role.
● Staff told us they had regular supervision. However, some staff told us that despite this they did not feel supported. They told us they had raised concerns that had not been addressed and said that they did not receive specific support after potentially distressing incidents. A member of staff told us, "Staff regularly get hit and kicked by residents. It is not nice. We don't always feel supported afterwards, it's just an expected part of the job."

We recommend that the provider consider the lack of training that was identified for some staff, and of the format their training is delivered, in order to provide staff with more applicable training to meet the needs of the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to moving in and this was used to develop a care plan. However, staff told us they did not always have time to read care plans, so the impact of care planning was limited and exposed people to the risk of inconsistent support.
● Overall, we found national 'good practice' guidance was followed. However, we found a drinks thickener, which could pose a potential risk to people; was not stored in line with national guidance.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to access a range of health and social care professionals. For example, we saw that appointments were made for people. However, the professional advice was not always incorporated in to care plans or followed.
● Care plans contained information about people's health conditions. However, as staff did not always read care plans there was a risk people may not receive the support they required to maintain their health.
● Systems were in place to ensure information was shared across services when people moved between them. This helped ensure people received person centred support when they moved between services, such as when going to hospital.

Adapting service, design, decoration to meet people's needs
● There was not enough equipment to meet people's individual needs. Some people required specialist chairs, staff told us people had to share these and this had a negative impact. For example, five people shared three adapted chairs between them, staff told us it was first come first served and those who got up later would have to stay in bed until a chair became free.
● Some areas of the home required redecoration to ensure good levels of cleanliness and improve the general environment. For example, some carpets were heavily stained. Decorative maintenance work was ongoing at the time of our inspection.
● Aids and equipment had been installed throughout the home. This enabled people with mobility needs to navigate around the building. Calls bells were available in each bedroom so people could request support.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Peoples rights under the MCA were respected. People told us staff listened to them and respected their choices. Where people did not have capacity to make decisions, best interest decision meetings had been completed by the nurse and the registered manager, or the commissioning professionals involved. Some people had a DoLS in place and we saw that the conditions were being met.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question deteriorated to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Staffing numbers had been a concern and we saw this had an impact on the ability of staff to demonstrate their caring approach; as people, relatives and staff all told us they did not have the time to spend with people.
- Staff were not always available to respond to people's anxiety and distress. One person told us, "I am fed up of being on my own all the time." Another person was in their bedroom and was visibly anxious and upset throughout our inspection. Staff told us this was a pattern of behaviour but, said they did not have enough time to sit and offer the reassurance this person needed.
- Despite staffing issues, we did see staff respond kindly to people even though they were very busy on the day of our inspection. One relative told us, "Staff are very cheerful and accommodating."

Supporting people to express their views and be involved in making decisions about their care

- Some people told us they were involved in decision about their care and support, however, this was not consistent. Staff told us they did not have enough staff to support one person who was at risk. To keep the person safe, they moved their chair around the home with them so that they could supervise them. This was not the choice of the person. Another person told us, the staff had put the radio on in their bedroom without consulting them, they said, "It's not my choice, I wouldn't have put it on."
- There was some evidence that people and their families were involved in care planning, however this was inconsistent.
- People had access to an advocate if they required one to help them express their views and there was information about advocacy displayed in the service. No one was using an advocate at the time of our inspection.

Respecting and promoting people's privacy, dignity and independence

- Throughout the day we observed many examples of kind, friendly and respectful interactions between staff and the people they supported. Staff made eye contact with people they spoke with, explained what they were going to do and gained consent before carrying out personal care.
- Whilst staff worked hard to respect people's dignity; the low staffing levels meant people needed to wait for support. This did not support their dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's needs were not always met. Care records showed several people had not been offered a bath or shower in the month leading up to our inspection. There was little evidence any oral care was being completed with people. Staff told us they did not always have time to support people's preferences in these areas due to low staffing levels. This did not meet people's needs and could have had a negative impact upon people's wellbeing.
- People were at risk of receiving inconsistent support that did not meet their needs. While care plans were clear overall, several staff told us they did not read care plans but instead learned about people's needs from other staff. This placed people at risk of receiving unsafe support that did not meet their needs.
- People were not consistently provided with opportunities for appropriate activity and occupation. The provider employed an activities coordinator for 12 hours a week. We saw that people enjoyed this and feedback was positive. However, at times when the activities coordinator was not around there was a lack of structure and stimulation for people. People spent their time watching TV, listening to the radio or were unoccupied.
- Staff did not always have time to engage with people. We observed staff were present in communal areas, primarily in a supervisory capacity. Although staff were friendly in their approach, they did not have time to meaningfully engage with people. This did not meet people's needs.

Care was not always appropriate to people's needs or in line with their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people had been supported to access the local community and to attend local places of worship. One person told us they attended a coffee morning in the local area with assistance from staff to attend, a relative spoke about the religious service which had been arranged within the home. The hairdresser visited every week and people looked forward to this as part of their normal routine.

Improving care quality in response to complaints or concerns

- There were mixed views about the responses from the provider management. Some people and staff told us they felt able to approach the management, other people felt their views were not listened to. There was a consensus that since moving the manager's office to the downstairs foyer; the registered manager was

much more accessible.
● A complaints procedure was displayed in the entrance foyer and the registered manager confirmed one complaint had been received since the last inspection. We saw the complaint had been fully recorded, including action taken, to the satisfaction of the complainant.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● We saw no evidence the AIS was met or had been addressed.

Supporting people to develop and maintain relationships to avoid social isolation;
● Other than the unrestricted visiting hours, there was little evidence of people being supported to maintain relationships. The inadequate staffing levels and limited activities meant people were often left isolated and unstimulated.

End of life care and support
● End of Life care was provided. A nurse told us, "We currently have one person on end of life care. As well as ensuring all [name's] needs are being met, we are also supporting the family as much as we can." The individual's care plan contained details of the end of life care provided and the anticipatory medicines prescribed.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Action had not been taken in response to known issues. This had a negative impact on the quality of the service. Staff told us they had raised concerns about staffing levels to the registered manager on several occasions. One member of staff told us. "Staffing levels are really bad - there are just not enough. We just get told to stop moaning about it, but it is not safe." Failure to take action to address staff concerns about staffing had led to potential risks to people and low morale in the staff team.
- Systems to ensure the safe running of the home were not effective. The provider reviewed the staffing levels weekly. This included reviewing individual's needs and other factors. However, this was based on inaccurate information as staff did not understand how to gather and record this information appropriately. This systems failure meant that no additional staff were deployed leaving people at risk of harm.
- Other systems and processes to monitor the safety and quality of the service were ineffective. For example, cleaning and maintenance audits had not identified concerns we found about the environment; such as the damaged areas and dirty equipment. This meant that quality audit checks were not effective and not consistently carried out.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- Staff did not feel valued by the provider or registered manager. There were mixed feelings expressed about the support staff received. Some staff told us that a failure to listen to their concerns about staffing levels and poorly maintained staff areas made them feel devalued.

Failure to establish and operate systems and processes effectively placed people at risk of harm and in receipt of poor-quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Immediately after our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report. In response, the provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk. Additional resources were also immediately deployed to the service.

- The manager understood their responsibility for reporting deaths, incidents, injuries and other matters

that affected people using the service.
● The ratings from our previous inspection were displayed so that visitors could see and read our report.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were opportunities for people and family members to share their views about the quality of the service provided. However, some people raised concerns that items discussed at the meetings were not always followed up.

Continuous learning and improving care; Working in partnership with others
● The provider had not consistently followed support and guidance from relevant partner organisations, such as external health and educational partners. This meant they were unable to help make improvements for people's care and safety at the service when needed. For example, we found inadequate record keeping evidencing they were following dietician advice.
● Commissioning professionals, such as the local authority, had completed monitoring visits and had confirmed the issues with lack of available staff, but they had complimented the caring attitude of those staff who were present. On the second day of inspection one visiting healthcare professional told us, "The staff are open and supportive. The improvement in my patient's overall presentation is largely down to the positive approach, consistent support and encouragement by the staff here."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager understood their duty of candour responsibility by contacting relatives after any incidents, or accidents. This ensured relatives were made aware of any outcomes following a concern.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care people received was not person-centred and did not meet their needs or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safety and risk were not appropriately assessed in relation to the environment, equipment and people's care needs. The provider had not acted when risk was highlighted to prevent avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to effectively assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The system to determine the number of staff required to meet people's needs was not effective. Staff had not received sufficient training to enable them to perform their role. The registered manager had not received sufficient training, supervision and support to enable them to carry out their duties.