St Philips Care Limited

Roxholm Hall Care Centre

Inspection report

Roxholm, Sleaford, Lincolnshire, NG34 8ND
Tel: 01526 832128
Website: www.stphilipscare.com

Date of inspection visit: 19 November 2014
Date of publication: 25/03/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 19 November 2014. This was an unannounced inspection.

The last inspection took place on 29 July 2014 and the provider was meeting the requirements of the law in the areas we look at.

The home provides residential care for 39 people who require care due to old age, dementia or mental health. It is located in the countryside four miles north of Sleaford in Lincolnshire.

There was a registered manager in place at this 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. However, on the day of our visit the registered manager was not available. There was a registered manager from another home the provider owned providing support and advice to people living in the home and staff. We have referred to them as the acting manager throughout the report.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the

Summary of findings

back of the full version of this report. People told us they were not happy living at the home. In addition, our own observations and the records we looked at highlighted there were concerns with the quality of service provided.

People's safety was being compromised in a number of areas and some staff we spoke with were unaware of how to raise a concern with the local safeguarding authority. During the inspection we identified a number of concerns which we raised with external authorities. Medicines were not always administered at the appropriate time and systems for recording the administration of medicines were not completed accurately.

The acting manager was aware of the recent changes in the Mental Capacity Act 2005 Deprivation of Liberty Safeguards and applications had been completed appropriately.

We found that people's health care needs were assessed and care was planned to meet those needs. However, people's care was not delivered consistently. In some cases, this either put people at risk or meant they were not having their individual care needs met. People were not always supported to drink enough fluid to meet their hydration needs.

People's privacy and dignity was not respected and people told us staff were not always kind and caring. People did not have access to appropriate private space where they could spend time with relatives when they visited. When people became agitated and restless they were not appropriately supported and this impacted on other people living at the home.

Care was based around completing tasks and did not take account of people's preferences. We were concerned that some people living at the home felt isolated as there were not enough meaningful activities for people either as a group or to meet their individual needs.

The registered manager investigated and responded to people's complaints, according to the provider's complaints procedure. However, some of the people told us the registered manager had not responded to concerns which had been raised with them.

Training was available for staff, however staff told us they did not have the time or resources to complete the training. Everyone we spoke with raised concerns about low staffing levels.

There was a lack of communication between the staff and the acting manager. This meant the acting manager was not aware of the issues which arose during the day of our inspection. This included a person's room being left in an unhygienic state, people were not supported to take their medicines at the right times and no hot drinks were available to people downstairs during the morning.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People we spoke with told us they did not feel safe in the home as there was a shortage of staff and staff were not always compassionate.

Care plans identified risks; however, the care delivered did not always ensure risks to people were minimised.

Medicines were not administered in a in timely fashion and poor levels of recording meant it was not always clear if medicines had been taken

Inadequate

Is the service effective?
The service was not effective.

Staff did not always have time or resources to complete appropriate training.

People were not supported to have access to drinks and staff were not aware of when to raise a concern if people were at risk of dehydration.

Inadequate

Is the service caring?
The service was not always caring.

Staff did not always support people to maintain their dignity and people told us that at time staff spoke sharply to them.

People were not supported to spend time in private when relatives visited.

Requires Improvement

Is the service responsive?
The service was not responsive.

People were not supported to take part in meaningful activities; this meant that people were less settled and happy in the home.

While people and their relatives were happy to raise concerns they told us that action was not always taken.

Inadequate

Is the service well-led?
The service was not well led.

There was a lack of communication between the staff and management in the home and staff told us they did not always feel supported by the provider and manager.

The providers systems to monitor the quality of service people received were not always effective.

Inadequate

Roxholm Hall Care Centre

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 19 November 2014 and was unannounced.

The inspection team consisted of an Inspector 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 the information we held about the provider. This included previous inspection reports, incidents we required them to tell us about and information given to us by the local safeguarding authority. We spoke with the local authority who place and pay for some people to live at the home and looked at their latest report.

We spoke with 10 people who lived at the home and three relatives who visited the home during our inspection, we also spoke with a visiting community healthcare assistant. We spoke with three care workers, a member of the domestic staff, the laundry assistant and the acting manager. We reviewed the care of five people by looking at their care and medicine records and reviewing management records. We spent time in the communal areas of the home observing care. Following our inspection we spoke with a healthcare professional who visits the home.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we had reviewed the information we held about the provider and saw that a number of concerns had been raised with us by staff. Concerns had been raised about the care people received from the night staff. We saw the registered manager had investigated these concerns and had taken action to resolve the situation. More recent concerns had been raised with us around staffing levels and during our visit the acting manager told us they were in the process of recruiting new care workers.

The provider had a safeguarding policy and a whistleblowing policy and staff were aware of how to raise any concerns they had internally to the manager or area manager. However, some staff were not aware of how to raise concerns with external agencies. We identified some concerns where we felt people were not getting their needs met, we reported these concerns to the local safeguarding team. However, staff had not recognised these concerns as leaving people at risk of harm. Records showed that safeguarding training had not been completed by all staff.

This was a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 safeguarding service users from abuse.

People told us and records showed the care provided did not always ensure people's safety. We raised the concerns we identified with the manager and they told us they would take action to resolve the issues. For example, one person had been having multiple falls, all the falls had been recorded and accident records completed. However, they continued to have falls and this was accepted as part of their condition. We discussed this with the manager who agreed to raise it with the condition specific nurse next time they visited to see if any action could be taken to reduce the risk of this person falling. We raised the individual concerns we identified with the action manager and they agreed to take appropriate action in each case.

We looked at people's care plans and could see that where risks to people had been identified these had been assessed. Care plans documented how risks to people should be managed to reduce the possibility that they were harmed. Where people were identified as being at risk of pressure damage, malnutrition and dehydration we saw extra monitoring should be in place.

However, we saw that care was not always delivered in line with people's risk assessments to keep people safe. One person who had their legs elevated said, "My [bottom] hurts." We asked if they were uncomfortable and they said, "Yes it depends how long I am sitting. I have been here a while today." We told staff this person was uncomfortable and they assisted them to stand to relieve their pressure areas. In addition we found that staff did not always use the correct pressure relieving equipment to keep people safe.

We saw extra monitoring charts were in place for some people recording how often their position was changed. However, we saw these were not accurately maintained. We saw one person's position change sheet had last been updated at 7:05pm which should have recorded 2 hourly repositions until midnight when a new chart was started. We looked at two other people's repositioning charts at 4:30pm we could see they showed people had not been re-positioned in line with their care plan. A member of staff told people had been repositioned when they went into lunch but the charts had not been completed. One member of staff told us they had been busy that morning and had not completed pressure area checks.

This was a breach of regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 care and welfare of service users.

People we spoke with commented on the shortage of staff and having to wait for help to go to the toilet especially at night. One person told us how when they ring the bell the member of staff comes and silences the alarm very quickly but tells them they have to wait until another member of staff is available. This wait had been up to an hour and 45 minutes.

Staff told us they were behind in the care they needed to give on the day of our visit due to being short staffed in the morning. They raised concerns that they had not been able to get everyone up before 11.15am and that people who had not been got up had not had a drink or anything to eat since the day before. Staff also raised concerns that due to the pressure to get everyone up they had not had time to leave rooms in a state fit for people to go back to.

The shortness of staff impacted on the care people received during the day. Breakfast should be between 8am and 8.30am but it had been started at 9.30am. Drugs had not been given out until a senior care worker started work at 9:15am and so people were received their medicine late.

Inadequate

Is the service safe?

There had been no mid-morning hot drink downstairs and upstairs the hot drink had not been offered until 11.30am. Staff confirmed that due to workload there had been no one in the downstairs lounge to monitor the people in there were safe.

A member of staff told us it was hard work at present as they are understaffed. They said, "I don't feel that I am giving the care I normally would." They also said, "I feel that I don't give them enough time. I am rushing all the while. I am not as satisfied with my job as I used to be." They said that often the number of care workers per shift was not enough as people's needs had increased and they needed more help. Another member of staff told us, "We are all at our wits end and people are saying why are you not seeing me."

The acting manager told us they were aware that some staff were doing excessive hours while more staff were recruited, However, they said that staffing levels had usually been kept at the scheduled level by using agency staff.

This was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 staffing.

The provider completed appropriate checks before new members of staff started work. A member of staff told us and records showed how they were required to have a DBS check and two suitable references before they started work.

People did not always receive their medicine in a timely manner. One person told us, "The tablet regime is very erratic. I haven't had them today." They told us they were in pain. We had heard this person asking the care worker for pain relief at around 1.30pm and when we checked their records 4:30pm there was no record of them taking pain medicine. Following our inspection the acting manager contacted us and told they had asked for the GP to review this person's pain relief to ensure they were no longer in pain.

The provider did not have systems in place to ensure any medicine prescribed by a visiting GP was obtained in a timely fashion. One person told us they had been prescribed medicine for a painful skin condition. The provider's policy meant they had to wait for the pharmacy to deliver the medicine the following day instead of a member of staff going to collect it. This meant the person was in pain for longer than they needed to be.

Medicines were stored appropriately and safely and access to medicines was restricted to trained staff.

We saw people were given their medicines and given advice on how they needed to take them. Medicine was not recorded as being given until after the person had taken it. However the actual time of administration was not recorded and medicines were signed as being given at 8am. This meant another member of staff may think medicine was administered promptly and offer further medicine without leaving the required time between doses.

We looked the medication administration records and identified a number of issues. We saw for five records there was no photograph to help staff identify they correct person to administer medicine to. We looked at five people's Medicines Administration Record (MAR) charts. We found there were gaps in the recording so it was not possible to know if medicine had been administered as prescribed. On the day of our visit we saw one person had their disease specific medicine signed as administered today at 8am and 12pm. However staff confirmed that this medicine had been administered late at 10:10am and 2pm. This meant the person was likely to have experienced more effects of their condition including mobility and ability to communicate. We saw their care plan recorded that medicines were to be given by a senior care worker at the times stated on the packet.

This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 management of medicines.

Inadequate

Is the service effective?

Our findings

A visitor we spoke with praised three members of staff and told us they were excellent carers. However, staff were not always aware of the care people needed or when to raise concerns with a senior member of staff. We asked one member of staff how often some people needed repositioning. They told us they had not read people's care plans and so they did not know people's care needs and relied on colleagues to prompt when repositioning should be completed. We asked the member of staff what level of fluid intake was acceptable and normal for people and when they should raise a concern to senior care workers or the manager. They told us they did not know what the acceptable fluid levels were.

New members of staff completed an induction which covered reading policies and procedures, fire and manual handling training, shadowing an experienced colleague for two days and computer based training. We spoke with a member of staff who was relatively new to the home. They confirmed they had completed some of the training as described above. However, they said they had not received any formal training in caring for people and they had not worked as a carer for older people before. They told us they had not had time to start their computer based training yet as things had been busy and they were working long weeks.

Training was provided for staff through a computer based package. However, staff told us they had no time to complete training on their shift and that the computer was in the manager's office which was locked when she was not around. We discussed this with the acting manager who had made arrangements for a computer to be available at all times. They had also informed staff they would get paid to complete training outside of their scheduled work times. Records showed that training had not been completed by some staff in multiple subjects.

The acting manager told us staff should receive a supervision every eight weeks. However, staff we spoke with told us they were not being supported with supervision. Records showed that only 50% of staff had received a supervision since 01 September 2014. There was no evidence that other staff had a supervision booked in the future.

This was a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 supporting workers

People told us the food was good and there was plenty of it. We spent time in the dining room at lunch time. We saw people were asked what they would like to eat and given a choice of two options. Where a person was unable to make a choice staff chose for them based on information held in the care files. People also told us if they did not like the choices on offer they could ask for something else.

We saw that lunch was not well organised, people were offered protective aprons half way through the meal and some were not consulted before the apron was placed on them. We saw in the upstairs dining room there were five separate occasions when the three staff supporting people all left the room at the same time. In the downstairs dining room people had adaptive equipment such as plate guards to help them maintained independence in eating. However, upstairs, support or adaptive equipment was not offered.

Staff told us that some people had got up late and had not had a drink or anything to eat since teatime the day before. Two people living at the home also told us they had not been offered food or a drink from 6pm the previous day. We discussed this with the acting manager who told us there was always a cold drink in available in people's room.

We saw that there was no mid-morning tea trolley downstairs so people were not offered a hot drink between breakfast and lunch. One member of staff told us this was because they were running late and wouldn't have been able to turn the pots round in time for lunch. We saw the upstairs tea trolley was taken round by the activities co-ordinator at 11:30am. A relative told us, "I got dad a drink as it had not come round." We asked if staff encouraged him to drink enough, they told us, "Some do some don't, it's a bit hit and miss." We saw in this person's care plan that they were at risk of dehydration.

Cold drinks were available but glasses and jugs of squash were placed out of people's reach, we saw in both lounge areas they were on a tall mantelpiece. During the day a person who was alone in the lounge area asked us to get them as some more drink as they were unable to get it and there were no carers about.

This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 meeting nutritional needs.

Inadequate

Is the service effective?

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards are laws which protect people's human rights when they are no longer able to make decisions for themselves. We saw there was MCA policy and a DoLS policy in place for staff to refer to. People's ability to make decisions for themselves were recorded. However, where people were not able to make a decision we did not see how decisions had been made on their behalf. There was no recording of what decisions had been taken in the person's best interest.

The acting manager was aware of the recent developments in legislation regarding Deprivation of Liberty Safeguards (DoLS). Records showed that where people were at risk of being deprived of their liberty, they had been referred to the local authority for assessment.

People told us they were able to access healthcare professionals when needed. People told us they were supported to access preventative care such as having a flu injection. A healthcare professional we spoke with told us they were happy that the manager and care workers raised changes in people's care needs with them appropriately.

Records showed people had been supported to access health care. We saw that people had been referred to appropriate professionals for advice and guidance to ensure care was safely delivered and met people's needs. We found one person had been referred for an assessment which had not taken place. We discussed this with the acting manager and following our inspection they contacted us to let us know the assessment had been completed.

Requires Improvement

Is the service caring?

Our findings

Staff did not always build positive caring relationships with people using the service. For example, person told us how they did not trust the night staff and could not rely on them to support them in a kind and caring manner.

We observed some positive examples of staff caring for people, At lunch time we saw one person ask which food choice had the most gravy. We saw the cook was aware of this person's food preferences and had brought a separate serving of gravy for them. However, we also saw some poor examples where people's choices were not respected. For example, We saw one person was assisted into the living room to have a seat. On the way they asked the staff where their cup of tea was. Staff responded that they had finished it and that the tea trolley would be around in another 45 minutes. They did not offer to go and get the person a fresh cup of tea.

When people became upset staff did not always provide comfort and reassurance in a positive way. One person was anxious and upset and not settled, they continually shouted out for help. The care worker was sat in the chair next to them completing paperwork and kept saying, "I'm right beside you." They took no other action to support the person to be calm and relaxed.

People's ability to make choices about their care was effected by the task orientated way the care was delivered. Staff told us how the routine of the home is normally set around tasks which need to be completed. For example on a normal day when they are fully staffed breakfast is at 8am so staff are expected to wake people up and get them to the dining room for breakfast. This is done even if it means waking people up to do it.

People were not supported to maintain their dignity. We saw one person had been dressed in trousers that were several sizes too big for them. The person found this distressing and continually pulled at the trousers and told us several times they were too big. We discussed this with the care staff and acting manager. No one was able to explain why they had thought these trousers were appropriate clothing for this person. There was no evidence that a lack of appropriate clothing had been raised with family or social care professionals to ensure the person had clothing which fit them. We found another person had not been supported to manage continence issues appropriately. A member of staff told us the person often removed their wet undergarments. This meant this person's dignity was not protected.

People were not given the opportunity to spend private time with their relatives. A relative we spoke with raised concerns they when they visited their parent they had to do so in the communal lounge. They explained that sometimes they wanted to discuss issues that were private. We saw there were no chairs in the person's bedroom. This meant the person was not able to choose to meet with their relative in a private area.

People's dignity was not always respected as people's belongings were not treated with respect. A relative we spoke with raised concerns about how the laundry was put away. They showed us the drawers and we could see clothes had been put in the drawer in any order and not placed nicely. The relative explained when the person put clothes on it looked like they had not been ironed as they had got creased in the drawers. The relative also raised concerns that clothes went missing or were shrunk in the wash and that they found items in the wardrobe that did not belong to their relative. Two relatives told us that clothes get in a muddle and get lost. One visitor said their relative was sometimes wearing other people's clothes.

One member of staff described how they helped people to maintain their privacy and dignity by knocking on doors, ensuring doors and curtains closed when giving private care and treating people with respect and compassion.

This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 respecting and involving service users.

Inadequate

Is the service responsive?

Our findings

During the morning we saw there were five people in the downstairs lounge, they were all asleep.

There was a large television switched on with the volume up loud. At the same time there was classical music on also loud. This meant it was hard to hold a conversation with people. People living with dementia may find this type of environment confusing and overwhelming.

The level of activities on offered to people depended on which floor of the home the person lived on. One member of staff told us, “Activities are mostly upstairs as you can get more out of them.” This meant people who frequented the downstairs lounge were not encouraged to take part in activities.

People with dementia were not always supported to undertake activities in a way them met their needs. For example, one person who wanted to paint was not left to do so in the way they chose and lost interest. Another person, who constantly wandered was left to do so unsupported. We saw this presented risks to themselves and others. For example, they would go into other people’s rooms and touch their belongings. This made other people frightened and angry. There was no care plan in place to ensure the person was actively monitored so they did not endanger themselves or others. There was also no plan around suitable activities engage the person and help them to be more settled.

People living with a dementia were not supported to access outside space unsupervised as staff were risk averse. One member of staff told us, “People don’t have access to outside space, not often. They can’t go out on their own as not secure enough.” However, we saw that people’s care plans recorded that they enjoyed gardening and being outside. This meant care was not planned to support their needs.

As people were not supported to be occupied they were at risk of placing themselves at harm. We saw one person had been left at the table for a while after lunch had finished and was getting agitated. They were trying to push their chair away from the table but were moving the table instead. We were concerned they may push the table onto their legs so we moved it for them. We saw another person in the dining room was trying to move a chair about.

Care plans had been completed and contained information about how people liked to receive their care. However, the care provided did not always meet people’s individual needs. For example, one person who liked to get up early was not supported to do so.

Care was not always provided to people at the time they needed it. A visitor told us how they often had to support their relative as staff had not been responsive to their needs. For example, the person had not been attended to after soiling their incontinence pad.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 care and welfare of service users.

People we spoke with told us they would be happy to raise concerns. However, they said that sometimes issues were not resolved. One visitor told us they had raised the issue about there being no chair in their relative’s room so they had no choice but to meet with them in the busy communal lounge, but no action had been taken. However, they had also raised concerns about medicine being administered at night. This had been discussed with the GP and the disease specialist nurse, care workers had been made aware this medication needed to be given, even if they had to wake the person to do so.

Another person told us they had put in a written complaint the day before our visit and were waiting for a reply from the acting manager. Records showed the provider had received three further complaints in the last 12 months and they had been investigated and appropriate action taken.

Inadequate

Is the service well-led?

Our findings

The provider was required to have a registered manager in post and there was a registered manager for the location. However, they were on unavailable on the day of our visit and an acting manager who was registered at another of the provider's locations had been in place for a week to support the service.

People knew that the registered manager was unavailable. However, they all said they could usually see the manager they wanted to.

The registered manager did not create an environment where staff felt able to raised concerns about the service. Staff told us they were reluctant to raise concerns as they did not trust the registered manager take action to resolve the issue or to deal with the issue fairly.

Staff were not supported to raise concerns about colleagues work practices. For example, a member of staff told us they had worked a night shift and had not been happy with the time other staff had taken to respond to people's needs. They told us they had not raised this with management as they were new and were not sure how the nightshift should work. This showed information on raising concerns and whistle blowing were not embedded into the culture of the service.

There was a lack of communication between the staff and the management of the home and staff were not supported to be open in how they were coping with the workload. During the inspection we identified a number of concerns around how the staff were managing the shift. We asked the acting manager how they had felt the day was progressing they told us, "It's been a busy shift but there have been no problems." They were unaware that the morning drinks trolleys have been late or missed completed, that staff had left a room not fit for the person to return to and that a person in the home had a contagious infection. This meant the acting manager was unable to respond to changes in care needs to ensure people were safe and high quality care was delivered.

The acting manager was not visible at all levels of the organisation. We asked a member of staff who worked upstairs if they felt supported by the manager. They told us that they didn't often see her upstairs and they felt segregated from downstairs. They also told us, "We have not had enough seniors [senior care workers] so I've felt I have to be the one to ensure I have passed all the information over." They told us they did not enjoy or want this responsibility.

The provider had a computer system which allowed management access to information in a timely manner. The acting manager was able to tell us how many falls people had or who had a pressure area that needed monitoring. The provider's quality audit manager was also able to view this information remotely and could support the acting manager if required. However, we identified a person who had a number of falls and no action had been taken to see if these could be reduced in any way. Audits which had been completed did not always identify issues, for example a medicine audit had been completed on 23 September 2014. It had not identified any of the concerns around medicines which we found during our visit.

The provider had not ensured the home was maintained to an acceptable standard. Some areas of the home were in need of decoration. We saw paint was chipped away from the skirting and architraves in some areas. In one room we saw wall to the side of the window was damp and the paint was peeling away from the wall. We saw in one of the lounges the carpet was stained and the wallpaper was ripped away from the wall in one place. We saw over lunch in the upstairs dining room staff were having to wash the spoons in between courses as they didn't have enough. This meant they were not on hand to support people to maintain adequate nutrition. A member of staff told us that there had not been a mid-morning hot drink offered to people as breakfast had been late and if they offered people a drink there would not be time to wash and have the crockery ready for lunch. This meant that the quality assurance processes in place around the maintenance and inventory were not effective.

People told us they were not asked for their views about how the home was run. Records showed no resident's meetings had been held in the last year and the annual quality assurance survey should have gone out in September 2014 but had not been sent out. Following our inspection the acting manager wrote and told us the surveys had now been sent to people.

This was a breach of regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The provider did not take steps to ensure that people were protected against the risk of receiving unsafe care. Care delivered did not meet people's individual needs and did not ensure their safety or welfare. (Regulation 9(1)(b)(i)(ii))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The provider did not ensure that there were suitable arrangement sin place to ensure that people were treated with dignity and had their privacy and independence respected. People were not treated with consideration and respect. (Regulation 17(1)(a)(2)(a))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: The provider did not ensure people were protected from the risks of inadequate nutrition and dehydration. Food and hydration were not available in sufficient quantities to meet people's needs and people were not offered support to eat and drink sufficient amounts. (Regulation 14(1)(a)(c))

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The provider did not make suitable arrangements to ensure that people were safeguarded against the risk of abuse. Reasonable steps were not taken make sure abuse was identified and reported appropriately. (Regulation 11(1)(a)(b))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The provider did not protect people against the risks associated with medicines. Arrangements for obtaining, safely administering, recording and disposal of medicines were not effective. (Reg13)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced people employed to care for people. (Regulation 22)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

The provider did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced people employed to care for people.(Regulation 23(1)(a))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The provider did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced people employed to care for people. (Regulation 10(1)(a)(b)2(c)(i)(e))