Bupa Care Homes Limited

Parklands Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 24 and 25 July 2017. The inspection was unannounced.

The service provides accommodation, nursing and personal care for up to 163 people. The home is split into six different units. Harrison and Collins can accommodate up to 30 people. Marlborough can accommodate up to 24 and Elmore which is a unit off Marlborough can accommodate up to 16 people. Clarendon can accommodate up to 33 and Samuel up to 28 people. All the units have their own separate living and dining spaces. There were 152 people living in the home at the time of our inspection visit.

Parklands Court Care Home was registered under the provider name of BUPA Care Homes (CFH Care Limited) up until February 2017. We were notified in December 2016 that the provider intended to simplify its structure and applied for all of its registered locations across the UK (which at that time were registered across 13 different legal entities) to transfer over to just two legal entities. This meant that Parklands Court Care Home became newly registered under the provider name Bupa Care Homes Limited in February 2017. Therefore, this was the provider's first inspection at this location since newly registering with us in February 2017. The inspection history for the location under the previous provider was used to inform the planning of this inspection because the management of the service at provider level had remained consistent.

Our last comprehensive inspection of this location took place in January 2016 and found improvements were required to ensure people always received a service that was safe, effective, caring and responsive. The reports from our previous inspections are available in the full history of inspection reports, which can be found in the previous provider's archived records for this location on our website at www.cqc.org.uk

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At the time of this inspection the manager had been in post for three months and was in the process of completing their registration with us. 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.

The provider had insufficient numbers of staff effectively deployed across all the different units to ensure people were safe. Staff were not consistently available to respond to people who needed reassurance to improve their well-being. The deployment and management of staff meant there were times when there were not enough 'eyes and ears' to monitor people safely as they walked around the home and interacted with each other.

Risks to people's health and safety were not always assessed and planned for. Some risk management plans had not been updated to reflect changes in people's needs to ensure people received consistent support to keep them safe. Improvements were needed in the management of medicines so people always received their medicines safely and as prescribed.

Staff and the manager knew how to report allegations of abuse. However, we identified occasions when people had been pushed over or hit by others which had not been reported to the local authority or ourselves as potential safeguarding incidents.

The provider checked staff's suitability to deliver care and support during the recruitment process. Staff received an induction and on-going training to carry out their role effectively. The manager had identified staff required further training to ensure they had the awareness and understanding to support people living with dementia.

People were not always appropriately supported when they had been identified as being at risk of malnutrition. Records to ensure people had enough to eat and drink to maintain their health were not always completed accurately. Where a need was identified, people were referred to other healthcare professionals to improve their health and wellbeing.

Staff demonstrated their understanding of the Mental Capacity Act 2005 and supported people to make as many of their own decisions and choices as possible. Staff sought people's consent before supporting them. Mental capacity assessments had been completed where it was believed that a person did not have the capacity to consent to a specific decision.

The provider had identified people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority in accordance with the legislation.

Staff were kind and caring but on some units staffing levels meant staff only had the opportunity to show kindness and care when they undertook a task or intervened in a situation. Staff were focussed on tasks rather than providing individualised care. When staff did engage with people, they were patient and reassuring. People were not always supported with personal care in a timely way to promote their dignity.

People did not always have interesting things to do on a regular basis. When people living at the home lacked stimulation, they could become unsettled. People were encouraged to maintain relationships important to them and visitors felt welcomed into the home.

People's experiences of care depended on which unit they lived on. Whilst some people's experiences were positive, other people experienced a level of care that fell below recognised standards and did not promote their health and wellbeing. The provider's quality checking arrangements were not consistently robust and effective in identifying, making and sustaining improvements in the quality of care delivered at the home. Managerial changes had led to inconsistency in leadership and this had impacted on the quality of care people received. Staff morale was low because they did not always feel listened to.

A new manager was open about the challenges they faced and the improvements needed to ensure the standard of care was consistent through the home. They had identified where improvements were needed and were committed to providing staff with the skills and confidence to provide safe and effective care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The provider had insufficient numbers of staff effectively deployed across all the different units at the home to ensure people were safe. Staff were not consistently available to respond to people who need reassurance to improve their well-being. Risks to people's health and safety were not always assessed and planned for. Plans to manage people's risks were not always followed to promote their safety. Some safeguarding incidents had not been reported to the local safeguarding authority as required. Staff were recruited safely and understood their responsibility to report any concerns about people's safety or wellbeing.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always appropriately supported when they had been identified as being at risk of malnutrition. Procedures to monitor how much people had to eat and drink were not always effectively implemented. Staff received regular training and were encouraged to complete qualifications in health and social care. However, training in supporting people living with dementia was not always effectively applied by staff in their interactions with people. Staff worked within the principles of the Mental Capacity Act 2005 and gave people choices about how they lived their lives.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not consistently supported in a caring and compassionate way. Staff were kind and reassuring, but often only had the opportunity to show kindness and care when they undertook a task. Staff did not always interact effectively to provide reassurance to people who were upset or anxious. People's privacy was not always protected and personal care was not always provided in a timely way which impacted on

people's dignity. People were encouraged to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not consistently receive care that was individualised to their needs. The information in people's care records was not always reviewed to reflect changes in their needs. More improvements were needed to ensure people were given opportunities to engage in meaningful activities throughout the day. People knew how to complain and share any concerns they had about the care provided.

Is the service well-led?

Inadequate

The service was not consistently well-led.

People's experiences of care depended on which unit they lived on. Whilst some people's experiences were positive, other people experienced a level of care that fell below recognised standards and did not promote their health and wellbeing.The provider's quality checking arrangements were not consistently robust and effective in identifying, making and sustaining improvements to the quality of care provision within the home. The deployment and management of staff did not always support the provision of high quality care. A new manager was in post and committed to building a strong leadership team and improve staff morale.

Parklands Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection visit took place on 24 and 25 July 2017 and was unannounced. The inspection was undertaken by six inspectors, one pharmacy inspector, two specialist advisors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of service. A specialist advisor is a qualified health professional.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

During our visit we spoke with 17 people and 34 relatives about what it was like to live at the home. We spoke with five unit managers, four nurses, 28 care staff, three activities co-ordinators, and two domestic staff about what it was like to work at the home. We spoke with the manager, deputy manager, night manager, clinical services manager and area manager about their management of the service. We spoke with three visiting healthcare professionals during our visit, and one by telephone afterwards.

We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool

(SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed 20 people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Inadequate

Our findings

The provider had insufficient numbers of staff effectively deployed across all the different units at the home to ensure people were safe. When we asked whether people felt safe at Parklands Court, they gave inconsistent responses depending on which unit they were living on.

Two relatives on one unit were concerned their family members were not always safe. One relative told us they were concerned because when their family member was in bed, others would regularly enter their bedroom. They told us, "Other residents keep coming in and out of my relative's room. Several residents came into my relative's room after dinner one day. I was frightened because some were tall blokes. They were walking around and I didn't feel safe for myself or my relative." A relative with a family member on another unit told us, "I don't think they have enough staff to check on people as often as they should. We frequently arrive to find [person] slumped in bed, uncomfortable and not having been turned for ages."

We saw staff were not consistently available to respond to people who needed reassurance to improve their well-being. For example, we observed two people continuously calling out. When staff had time to individually attend to these people, they became calm and their well-being improved. When staff moved away to support other people, they became unsettled again and starting calling out. One relative told us, "This is every afternoon, I can't talk to my relative because of these two residents who keep calling out. It's continuous every day, it never stops and it's having an effect on me. Staff are never here, if they sit with them they stop. The continuous shouting upsets my relative and their GP has said they should be somewhere quiet. There is not enough staff, they should be continuously in the room." Another relative said there were not enough staff to provide personal care and support with meals, "They could do with extra staff. Sometimes the main floor is left unsupervised. Sometimes staff are rushed off their feet and don't have time to reassure residents and spend time with them."

Staff raised concerns there were not always enough suitably qualified and experienced staff to respond to the needs of people. Staff told us if there were shortages on one unit, staff would be moved from other units. One staff member told us, "If we lose staff it's not safe as we can't deliver personal care. If we have a full complement the staffing is okay, but usually we are short through sickness." They also said, "If we have less than the full number, there are risks to people and the quality of care suffers." Another staff member told us, "I wake up at night worrying I have missed something. I never go home feeling I have done a good job."

Staff on three of the units told us insufficient staff impacted on providing personal care and meeting people's hydration and nutritional needs. One staff member explained, "We have to go straight from

breakfast into turning people, so there is no time to give people a wash." On one unit we saw people were still in bed or in their rooms at lunch time. There were not enough staff to deliver the level of personal care people required due to their dependency levels. Staff confirmed it was not unusual for some people not to be washed or supported with personal care until after lunch.

Staff we spoke with told us people who were funded for one to one care did not consistently receive this one to one support. One member of staff told us, "We have a person on one to one but the majority of the time, we don't have enough staff." On several occasions on the first day of our inspection we observed the only member of staff in the lounge was the one providing one to one support to a person identified as being at high risk of falling. The staff member was therefore unable to monitor the rest of the people in the lounge or safely intervene or divert others who presented at risk. On one occasion we walked into the lounge and saw a person had fallen from their chair and was lying on the floor. The staff member was unaware as they were observing the person on one to one. We alerted other staff so they could support the person who had fallen.

We looked particularly at staffing levels in one of the units supporting people living with dementia. People were at risk because there were insufficient staff to monitor them safely. The layout of the unit presented challenges as corridors and bedrooms were not always in view, and people who spent time in these rooms, were not always checked and observed. Staff were not always available to observe those people who were independently mobile and liked to explore their surroundings. One member of staff explained, "The people who walk about we have to know where they are all the time to reduce the risk of them hitting each other and slapping each other." One staff member told us, "On this unit we normally work with six (care) staff in the morning and five in the afternoon. With these numbers we are only allowed to give basic care and don't have time to provide quality care. For a unit of this size with only six (care) staff, the corridors are unmanned and people are at risk. Normally there are people going into other people's bedrooms, sometimes found asleep on other people's beds." Accident and incident reports showed there had been episodes when people had entered other people's rooms unobserved and incidents had occurred.

On the day of our inspection we saw insufficient staffing levels had a significant impact on the standard of care provided in Clarendon, Marlborough, Collins and Harrison Units. We found this was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing

On those units where there were sufficient staffing levels, people received the care and support they needed. Staff had time to spend with people and we saw many positive interactions. Positive comments from people and relatives included: "I like my room and I feel safe in here because there are lots of people around to help me", "I feel safe in my room with my things around me and there are nice carers here to help me" and, "I definitely trust the staff, our relative is definitely safe here. Every time I have seen our relative moved around and hoisted, it is done safely. They look after our relative very well."

Following feedback from our inspectors, on the second day of our visit the management team increased the number of care staff on Clarendon Unit. We saw there was an immediate improvement that had a positive effect on the people who lived in the unit. One member of staff told us, "It is much calmer today. Yesterday we were a couple of carers down and it makes that big difference." A visiting relative confirmed, "It is quieter today than usual."

People were at potential risk of harm because risks to people's health and safety were not always assessed and planned for, particularly on Clarendon Unit. Staff did not always have the information they needed to manage people's behaviours that challenged in a safe, effective and consistent manner. For example, on the second day of our visit we saw a person asleep on the bed in another person's room. We alerted staff who immediately supported the person to move to their own bedroom. However, when we looked at this

person's daily records, we saw they had slept in the same person's bedroom for several hours on the previous day and staff had left them there. When we looked at the records of the person whose room they had slept in, we saw they were independently mobile and could display some agitated behaviours and aggression. One of the triggers to this aggression was, "[Name] does not like their personal space being invaded by others."

We found inconsistency in staff following risk management plans to keep people safe. We saw examples where staff were aware of the risks to people and managed them safely. For example, one person who was at high risk of falls and chose to spend a lot of their time walking around the building. Their risk assessment provided guidance for staff to reduce the risk of them falling. Our observations assured us staff knew how to manage the risks to this person because a staff member moved a small table so the person would not trip over it. Staff demonstrated a positive approach to risk taking and recognised that whilst walking around presented a risk; they respected the person's decision to do so and did not try to stop them.

However, we found the plans to manage some people's risks were not always followed to promote their safety. For example, one person needed to be hoisted for transfers. Their risk management plan stated staff should use a small size sling. We spoke with two staff who told us they always used a medium sized sling. They were not aware of the correct information in the care plan. We spoke with a member of nursing staff who confirmed that using the incorrect equipment could result in serious injury, such as a fall if the sling was too big or skin damage if it was too small. Another person had been identified as being at risk of skin damage. Their care plan stated they needed to sit on a pressure relieving cushion at all times. We saw the person was seated in the lounge for most of the day with no pressure cushion in place which placed them at further risk of skin damage.

We found care and risk management plans had not always been updated to reflect changes in people's needs. One person's care plan dated 3 February 2017 said they were able to walk around independently. The plan had been reviewed on 29 April and 18 June 2017 and still indicated they were independent. However, we were told the person had not been able to walk for some weeks. There was no plan to reflect this change in need and no information to inform staff how they needed to support this person during transfers. One staff member told us the person needed to be hoisted for all transfers, but another staff member told us, "They can transfer with the assistance of two. We don't hoist them." Staff were not working consistently to meet this person's needs and manage the risks associated with their mobility and moving and handling.

A pharmacist inspector looked at how medicines were managed across three units at Parklands Court. We were particularly concerned about the management of diabetes for one person on Clarendon Unit. This person had been prescribed insulin to be used when their blood sugar results were high. The records showed the insulin was not being used at these times which exposed this person to further diabetic complications. We shared this with the management team, who said they would review immediately and take action.

We found the Medicine Administration Record (MAR) charts on two of the units were good and demonstrated people were getting their medicines at the times they needed them. However, on Clarendon Unit there were discrepancies between the quantity of medicines found and the administration records. Staff had not always signed the administration records so we were unable to establish if the medicines had been given to people correctly. We also found examples where administration records had been signed to confirm administration had taken place, but the medicines had not been given. For example, the records for an inhaler with a dose counter showed that 30 doses were available at the start and 28 doses had been administered. We therefore expected to find two doses remaining, however we found 15 doses.

We looked at the temperature monitoring of the refrigerators used to store medicines across all three units. We found medicines being stored in the refrigerators on two units were being stored at the temperature recommended by the manufacturer. However on Clarendon Unit, records showed the temperature was regularly higher than recommended and no action had been taken. This put people at risk as the medicines may no longer be effective.

We looked at the records for people who were having pain relief patches applied to their bodies across all three units. On all three units we found by speaking with staff and reading the records, that the rotation of patches was not in accordance with the manufacturer's guidelines. This meant the provider was not ensuring the possible side effects with these patches were kept to a minimum which could impact on people's well-being.

We found where people needed to have their medicines administered directly into their stomach through a tube, the provider had not ensured the necessary information was in place to ensure these medicines were prepared and administered safely.

We found where people had to have their medicines administered by disguising them in food or drink, the provider did not have all the necessary safeguards in place across all three units to ensure these medicines were administered safely. For example, we found the provider was not able to consistently demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered.

The provider had not consistently ensured risks to people living on Clarendon Unit were identified, that guidance was in place, and staff followed the guidance. The provider also had not ensured people on Clarendon Unit always received their medicines in a safe way. We found this was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 in respect of Clarendon Unit. Safe care and treatment.

Staff understood the procedure for recording and reporting accidents and incidents. They explained how they completed an accident and incident form and informed the management and relatives. They told us they would reflect on the incident and consider best practice as a result. One member of staff explained, "If there is an accident like a fall, I would see to the resident first and record full details in the care plan and accident report. I would tell the unit manager and if there were injuries I would map them."

During our visit we looked at accident and incident reports on Clarendon Unit which supported people living with dementia. We identified occasions when people had been pushed over or hit by others which had not been reported to the local authority or ourselves as potential safeguarding incidents. For example, on the 28 January 2017 one person was 'attacked' by another person. The person hit back, became unbalanced and fell over. On 17 March 2017 one person was found on the floor of the lounge with another person standing over them. They said the other person had punched them. On 19 April 2017 one person hit another person with a small object causing a graze to their lip. None of these incidents had been reported as safeguarding issues. It is important such incidents are reported to keep people and others safe when they demonstrate behaviours that can cause distress or injury.

We found this was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 in respect of Clarendon Unit. Safeguarding service users from abuse and improper treatment.

Staff understood their responsibilities to keep people safe and demonstrated their awareness of what constituted abuse or poor practice. One said, "Abuse could be neglect, unexplained bruising or self-harm. I have a duty to keep people safe." Staff had completed training in safeguarding and knew what they should

do if they had any concerns about people's safety or they suspected abuse. Staff understood the importance of reporting concerns to a senior member of staff. One said, "I would report it straight to the nurse or senior carer. They would tell the manager and they would decide what action was needed." Staff felt confident any allegations made would be fully investigated to ensure people were protected. One staff member told us, "If I thought action had not been taken, I could phone the council or CQC."

The provider's whistleblowing policy was on display for staff. A whistleblower is a person who raises concerns about wrong doing in their workplace. Staff confirmed they were confident to raise concerns if they witnessed poor practice. One staff member told us, "I have done safeguarding training. If I thought someone was being abused, I would speak to the unit manager. I'm fully confident it would be dealt with. We have a whistleblowing policy, but if I had any concerns I would speak to our manager. You can't fault her at all."

Staff were recruited safely because the registered manager checked they were of good character before they started working at the home. The registered manager had obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

The provider had taken measures to minimise the impact of unexpected events. For example, there was a fire procedure and fire risk assessment on display in communal areas. This provided information for people and their visitors on what they should do in the event of a fire. A staff member said, "If we hear the alarm we know to stay calm and offer people reassurance as some people will be upset by the noise. The senior or nurse will advise us what to do." Another said, "We have regular training but the most important thing is to reassure people it will be okay." Personal evacuation plans were available to staff so it was clear what support people would need to evacuate the building if this was necessary. These plans had been reviewed monthly to ensure they contained up-to-date information.

Requires Improvement

Our findings

We found people had a different meal experience depending upon which unit they lived. We saw and staff confirmed that some people did not always get the support they needed to eat and drink. Staff told us staffing levels meant those people who took the longest time to help, did not always receive the assistance they required at meal times. On Collins Unit we saw six people needed support to eat. Three care staff supported three people, but the meals for the other three people were left to go cold while they waited for assistance.

People were not always appropriately supported when they had been identified as being at risk of malnutrition. We looked at the care plans for two people who needed assistance with eating. Staff told us there were not enough staff to sit with these people and encourage them to eat. One staff member explained, "We do make sure people see GPs and dieticians about weight loss and they are prescribed supplements, but if we don't get the food down them, how can we give them supplements?" We saw both people had lost weight regularly since living at the home.

The advice and recommendations from health and social care professionals was not always clear in people's care plans. We looked at the records of one person who had lost 7.8kg in six months. The person had been referred to a dietician and the Speech and Language Therapy Team (SALT), but there was conflicting evidence in their nutritional care plan as to whether there was a risk of them choking on normal fluids. On the day of our inspection we saw the person was given thickened fluids, but the thickener used had been prescribed for another person. We were not able to clarify what the most up to date nutritional advice was for this person. The unit manager assured us this would be followed up straight away to ensure the correct advice was followed.

Some people were on food and fluid charts because they were at risk of not eating and drinking enough. On some units these had been fully completed by staff, but this was not consistent throughout the home. A dietician had advised that one person needed to consume a set amount of fluid each day to maintain their health. Two staff we spoke with were unaware of the amount of fluid the person needed. Another person needed support with drinking. Staff told us they did not consistently have time to do this. The unit manager had introduced a 'fluid intake safety cross' to monitor whether the person was receiving the assessed safe amount of fluids each day. Records showed the person had only received the recommended amount on 13 of the 23 days prior to our visit. We were told 17 of the 29 people on the unit required one to one support when drinking. The fluid safety cross system was to be introduced for all 17 people as there had been an increase in the number of people with urinary tract infections.

On one unit we observed several occasions when people asked for drinks. One person asked for a drink and showed us their beaker was empty. We asked if they were thirsty and they responded 'yes'. The person had found an 'ice' beer mug which had a sealed outer wall filled with a coloured freezeable liquid. The person was trying to drink out of the mug and was tipping it right back, clearly confused as to why they couldn't drink the liquid. When we asked a member of staff if it was an appropriate object to have in a dementia care setting, they prompted another staff member to take it away. Neither staff member considered that the person was thirsty and offered them a drink.

Some relatives raised concerns about people not being given enough to drink and records not being accurate. One relative told us, "They complete a fluid and food chart but it is not accurate. We are supposed to be encouraging fluids. His fluid chart states he had 200mls of milk on his breakfast but his food chart says he refused his breakfast so he didn't have the 200mls they stated. I am concerned about this."

Food charts did not always give an accurate picture of what people had eaten. One person's food chart recorded that at lunch time they had eaten 'puree meal - ate all' and 'soft dessert- ate all.' There was no information about what food they had actually eaten, how much or whether it had been fortified with extra calories. This information is important so other healthcare professionals involved in people's care can get an accurate picture of what people have actually eaten and staff can identify what meals people have enjoyed.

On one unit we identified systems were not robust enough to ensure people's oral and dental care needs were met. There was no system to arrange check-ups and people only had a dental appointment when a need was identified. One person's records indicated they had lost their dentures a week prior to our visit. There was no evidence of any action being taken to rectify this. Ineffective systems could have a significant impact upon people's nutritional intake as it may affect their ability to chew and manage textured food and their appetite may be affected by any untreated pain.

On the day of our inspection we found people's nutritional and hydration needs were not being met on Clarendon, Harrison, Collins and Elmore Units. We found this was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014 in respect of those four units. Meeting nutritional and hydration needs.

On other units people had a more positive experience at mealtimes. People told us they had a choice at meal times. Comments included: "The food is good here, if I don't fancy anything I can have something later" and, "The food is good and there is a choice."

Generally people were positive about the effectiveness of staff at Parklands Court. Comments included, "Staff seem very well trained. They move our relative with a hoist, it is always done without fuss and safely. I do have confidence in the staff. I think they are pretty good" and, "The staff seem very well trained and professional in my view. They have a difficult job as our relative can be very aggressive, but they know how to support [person]."

Staff told us they received on-going training and were encouraged to complete qualifications in health and social care to enable them to carry out their roles effectively. Comments included, "The training is okay", "Training is excellent" and, "I have learnt a lot, we have a training academy."

Some staff had completed dementia awareness training and managing behaviours that could be challenging, and felt this enabled them to support people living with dementia effectively. One staff member told us, "I have been trained in challenging behaviour and would only intervene if they put themselves or others in danger. We are not taught to restrain people, we let them calm down or we distract them." Another

said, "I did breakaway training last year, but we are trained to use distraction techniques first to reduce anxieties," However, other staff felt the training was very basic and more in depth training would be beneficial so they could be more effective. Comments included, "We did basic training but nothing in depth, I would like some more" and, "Yes we had dementia training but it was just a talk and a quiz at the end, nothing much really."

During our visit we saw occasions when staff did not interact effectively with people living with dementia. For example, one person was sitting in their lounge chair holding a tablecloth. A staff member tried to remove the tablecloth from the person who was resistive and became upset. The staff member continued to try and remove the tablecloth until the person let go. The staff member had not considered offering the person something to hold as an alternative to the tablecloth. On several occasions people raised their voices at each other which then caused others to start shouting. Staff did not seem to be aware of the impact this behaviour had on others in the room. They did not distract these behaviours to provide reassurance and prevent behaviours escalating and causing anxiety to others. The manager acknowledged there were staff who required additional dementia specific training, and she told us there was a plan in place to ensure all staff had the appropriate skills.

New staff members received effective support when they first started working at the home. Staff confirmed they had completed an induction in line with the Care Certificate. The Care Certificate is an identified set of standards for health and social care workers. It sets the standard for the skills, knowledge, values and behaviours expected. Comments included, "Yes, I had a really good induction. I worked alongside the team for a couple of weeks and completed training I needed" and, "My induction consisted of various training, including completing the Care Certificate. Training was practical and I did a period of shadowing." Staff explained the induction had given them the confidence they needed to do their job. It ensured they understood their responsibilities in line with the provider's policies and procedures.

Staff told us they had regular opportunities to meet with managers and senior staff to discuss their role and developmental needs. One staff member told us, "I have supervision every six to eight weeks with the unit manager. It is private and confidential, you can talk about anything." Another told us, "I do have one to one supervision. We discuss personal issues and my training needs and to keep abreast with new developments." One member of staff told us seniors and the unit manager worked alongside staff and would let them know if their practice needed improving. This reassured them they were doing things well.

However, clinical staff told us there were no formal arrangements for regular clinical supervision or peer group meetings. Such meetings would offer clinical staff an opportunity to reflect on their practice and share experiences to ensure excellence in clinical practice within the home. The new clinical lead explained this was something she was arranging as a priority.

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 an assessment shows a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People's records confirmed decision specific capacity assessments had been completed and best interest meetings had taken place if people did not have capacity. For example, one person was unable to consent to dental treatment and a best interest meeting had taken place which had included their GP and relative

who held Power of Attorney. The person's relative confirmed they had contributed to discussions and said, "My views were listened to as I know [person] best."

Staff demonstrated their understanding of the MCA as supporting people to make choices. One staff member explained, "Mental capacity is about people making choices. Everyone has the right to make their own decisions." A person confirmed, "The carers show me my clothes and I can choose what I want to wear." Throughout our visit we saw staff seeking consent and approval before supporting with people, such as providing support with personal care. For example, one care worker asked a person, "Is it alright if I cut up your food?" The care worker then waited for a response before assisting them. This showed us they understood the principles of the MCA and knew they could only provide care and support to people who had given their consent. One staff member explained, "I never assume people are consenting so I explain and give them choices. I support them to make a decision like what they want to wear and where to sit."

DoLS applications had been made on a case by case basis, following an appropriate assessment of each person's capacity and care arrangements. Some people had an authorised DoLS in place because their freedom of movement had been restricted in their best interest.

People's records showed us how the home's staff worked in partnership and maintained links with health professionals. For example, chiropodists and advanced nurse practitioners. Where changes in people's health were identified, they were referred to the relevant healthcare professionals to meet their health care needs. For example, one person identified as being at risk of falls had been referred to the falls prevention team. Any healthcare professional involvement was discussed during 'handovers' so staff had information to provide effective care.

We spoke with two visiting healthcare professionals. One told us they were 'very impressed' by the information and support they received from staff, especially the unit manager. The other described staff as 'very helpful' and said staff were 'organised with good communication'.

Requires Improvement

Our findings

We found people were not consistently supported in a kind and compassionate way. On some units staffing levels meant staff only had the opportunity to show kindness and care when they undertook a task or intervened in a situation. Relatives with family members on some units raised concerns about staff not having enough time to spend with people. Comments included: "I think most of them do care, but they don't really have the time to do everything properly due to limited staff" and, "More staff would help as they never seem to have time to spend with people."

On Clarendon Unit we saw several occasions when people's requests for support were ignored by staff because they were busy carrying out other tasks. For example, we heard people asking for physical support, such as requesting drinks. People's requests for support were ignored by staff who carried on completing other tasks. We saw one member of care staff spent 40 minutes folding laundry rather than providing physical and emotional reassurance to those people who were anxious or distressed.

One person became increasingly distressed during lunch and repeatedly asked to go home. Another person informed them, "You can't go home, they lock all the doors so we can't get out. They put stuff in the food too." Staff who were present did not intervene to offer comfort or reassurance to either person.

Another person kept trying to stand from their chair. When they were unable to, they became distressed and upset. When we raised this with a member of staff we were told the person was safe as they weren't able to stand. The staff member did not respond to the person's anxiety or distress. We asked another member of staff about the person. They told us, "[Person] used to be able to mobilise but they had a series of falls. [Person] tries but they aren't able to mobilise at all. They will cry because they can't understand why." Staff missed the opportunity to reduce this person's distress at the loss of their independence.

On Clarendon Unit people's privacy was not consistently maintained because we saw other people were walking in and out of their bedrooms uninvited. A relative told us their main concern was that personal items often went missing and they had seen other people going through their family member's belongings. They explained, "Sometimes I can go in [person's] room and one person will be lying in their bed and another will be sitting in their chair."

Staff on Clarendon, Collins and Harrison Units felt personal care was not always undertaken promptly which impacted on people's dignity. They told us personal care sometimes suffered because other tasks were prioritised. Our observations confirmed that people were not always supported with personal care in a

timely way. On the first day of our visit one person remained in their night clothes and dressing gown asleep at the dining room table. Staff did not approach this person to encourage and assist them to get dressed and they remained in their night clothes until lunch time. Another person's records indicated they had not had their hair washed for three weeks. There was nothing in their care plan to demonstrate this was their personal preference. A relative raised a concern about nail care. They told us, "One thing that does get me is nails. There is no need for anybody to have dirty nails because that is where bacteria starts. His nails were dirty until I said."

People's dignity was not consistently promoted. On Clarendon Unit people were referred to by their room number rather than their name. For example, 'room one is hoisted'. During our visit one person fell over in the foyer on Clarendon Unit and staff had to use a hoist to lift them off the floor. One staff member took the lead and offered eye contact and reassurance which appeared to comfort the person. However, three visitors and two other people were in the foyer. Staff did not ask the people to move away or put a screen up to preserve the person's dignity. We also saw an occasion when a person was led by a staff member through a communal area, inappropriately dressed so their dignity was not maintained.

On the day of our inspection we found the privacy and dignity of people was not always promoted on Clarendon, Collins and Harrison units. We found this was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 in respect of those three units. Privacy and dignity

Where staff had more time, we saw positive interactions between staff and the people they supported. On some units staff knew how to comfort people and used appropriate distraction techniques when people became anxious. For example, one person became tearful and staff promptly provided reassurance and a hot drink which reduced the person's anxiety. Another staff member spent time reassuring a person who was very confused and upset. They encouraged the person to have a chat and a joke and the person visibly relaxed and became calmer.

When staff did engage with people, they were patient and reassuring. For example, one member of staff sat quietly talking with a person and stroking their hand. Another staff member sat on the floor next to a person because this made it easier for the person to have a conversation with them. Another member of staff noticed a person was wearing a new top and took time to say, "That's a nice coloured cardigan you have got on there." This was particularly valued by one relative who told us, "Staff are very respectful when they handle my relative. They are always kind and fully explain things. They have a very professional approach with all the residents."

People on some units spoke highly of the care staff and the care they received. They told us staff were kind, caring and compassionate in their approach. Comments included: "The carers are very friendly and I get on really well with most of the regular staff", "Mostly they are kind and considerate and respect my wishes" and, "The girls here are wonderful, they look after me really well." Relatives generally shared people's views. They told us, "Carers are lovely and they are very friendly to Mum" and, "I like it here, I think it is superb. They (staff) react so well with our relative and are very respectful."

Staff showed concern for people's wellbeing. One staff member commented, "'I like to think I treat these residents like I would treat my own family, and how I would hope my own family would be treated by someone else. We do get a bond with people because we are with them every day…it's hard not to.'' During our visit we saw many caring and respectful interactions between staff and the people living at the home. Staff maintained eye contact when talking with people, by crouching down beside their chair and looking directly at them. This caring approach was confirmed by a relative who told us, "I see the staff are really caring and genuinely kind with people."

On some units of the home we saw staff supported people to maintain and regain their independence wherever this was possible. For example, they gently reminded people to take their time when they were walking along corridors and encouraged them to wear their spectacles so they could see where they were walking. This meant people were less reliant on staff to guide them.

We saw staff knocked on people's bedroom doors and announced themselves before entering. One staff member waited on a chair outside a bathroom and explained, "When the person is ready they give me a shout. I won't go in until they are ready." This showed staff respected people's right to privacy. A relative confirmed, "Staff are very respectful, they knock on doors and speak to our relative in a lovely manner. I have absolute confidence in them."

Relatives felt their family members were treated with dignity and respect. A typical comment was, "Staff are very respectful when giving personal care to my relative. They even ask me to leave the room. They close the doors and curtains and I certainly have no issues. My relative is always clean and well presented. Any accidents and they are always changed." A member of staff explained how they always checked that people were dressed appropriately to maintain their dignity. They went on to say they asked people daily if they wanted a bath or a shower and knew what people preferred. Another staff member told us, "Dignity and respect are very important when personal care is being delivered. I talk and communicate with them."

People were encouraged to maintain relationships important to them. Staff recognised the importance of ensuring people's relations felt involved in their family member's care. One explained, "Whilst they are here I will go in and ask if they are okay and if they need anything. I make them feel welcome and let them know if they have any concerns, I am always there if they need to talk." Visitors told us they were able to visit when they wished and felt welcomed into the home. Comments included: "Relatives are encouraged and made to feel very welcome", "I can come whenever I like, there are no restrictions" and, "We are always welcomed, doesn't matter when we come it's always fine."

Requires Improvement

Our findings

Some people told us staff were responsive to their needs and listened to what they had to say. Comments included: "The staff always listen to me and never force me to do anything. They respond well to any of my requests and I have no concerns that I would be ignored if I was worried about anything" and, "They usually listen to me and bring me whatever I want." This was confirmed by relatives on some units who told us, "All the staff are willing to discuss [person's] care and I think they are very responsive to the changing needs she displays" and, "I think the staff are very responsive to the needs of the residents".

However, we found people did not consistently receive care that was individualised to their needs. On one unit care staff were concerned they could only respond to people's basic care needs and could not always be responsive to people's emotional and social care needs. One staff member told us, "It is basic care they are getting, you can't give quality care." Another said they could not provide personal care to meet people's preferences and explained, "Two or three don't have personal care until the afternoon if we haven't got to them by lunch time."

We also observed occasions when staff were focussed on tasks rather than providing individualised care. On two units some people became unsettled and when staff did not respond, the behaviours started to escalate and have a detrimental effect on others in the room. One staff member told us they knew people needed more of their time and explained, "I think 'I want to sit and talk to you, but that person needs changing and I have to go and do that'."

On the second day, when staffing levels had been increased, people were much calmer and more relaxed. One member of staff explained how having more time for people improved the quality of care they received. They told us, "This morning I had time to talk to them and ask them if they wanted this skirt or that skirt and allow them to make their own choices." They went on to tell us about one person who was normally very resistant to personal care and said, "This morning, whether I seemed calmer because I wasn't rushed, but they were calmer. They seemed to pick up on it."

On other units we saw positive responses from staff towards people that were personalised to their needs. For example, one person requested a cardigan because they felt cold. This was quickly provided and the staff member asked if they would also like the window closed. Another person requested more sugar was added to their cup of tea. More sugar was quickly provided. One person asked a member of staff if their relative was visiting later on in the day. The member of staff offered them reassurance and explained their visitor would be arriving later. The person responded well to this by clapping their hands and smiling. The

staff member explained it was really important to offer the person reassurance when they asked because they often felt worried their relative had forgotten about them.

Each person had a care plan which was detailed and included personal details which were specific and relevant to their individual needs. One member of staff explained, "Everything is about the person, it's their life, their choice and we go by what they say." However, we found inconsistency in the accuracy of the information in the care plans. On one unit records showed people's needs and abilities were reviewed every month and their care plans were updated when their needs changed. However, on another unit we found care plans had not been updated when there was a significant change in people's needs, such as a change in their mobility or behaviours. In some cases this had resulted in people receiving inconsistent care.

Relatives told us they felt involved in their family member's care and were always consulted or updated by staff. Comments included: "They do reviews of my relative's care often and always ask for my opinion or concerns. I do feel very involved in the care my relative receives."

We found people did not always have interesting things to do on a regular basis. Staff told us when people who lived at the home lacked stimulation they could become unsettled. During our inspection we found some people had interesting things to do, however other people were left in their rooms for long periods of time with little or no stimulation. In some of the communal rooms people had access to a member of staff who supported them to be involved with activities such as completing word searches, puzzles, pampering sessions and chatting. However, at other times we saw people sat for significant periods of time with no stimulation or distractions and no staff encouragement to engage in an activity. Several people spent long periods of time asleep. Staff told us they did not have time to sit and chat with people, which would improve people's well-being.

Staff told us some group activities did take place, but more would be beneficial. One member of staff said, "More activities would keep people awake and give them something to focus on. I think some people get a bit bored." Other staff told us, "We have one resident who is religious and a priest or nun will visit. They respond very well and really like it," and, "I just feel there is not enough structured activities to keep people engaged and stimulated." This view was shared by relatives who commented, "I think the activities lady has to cover all the units so we don't see much of her usually. She was very supportive in organising a birthday party" and, "I think they do sometimes organise some singing or music."

People told us they would report any complaints or concerns to senior staff or managers. People told us, "No complaints at all about here, I know who to complain to, but really there is nothing to complain about", "I know who the manager is and I would complain to her if I was not happy" and, "I have never had to complain, but I feel sure that if I was concerned I could speak with the manager and she would listen and be responsive."

Some people told us they had raised concerns, but did not feel they had received an adequate response. One relative told us, "We don't get [person's] post very quickly and one letter had been opened. I complained to the manager and we didn't have an explanation as to why it had gone missing."

However other people felt their concerns had been listened to. One person told us, "I have never made a formal complaint. I have raised issues which were immediately addressed." A relative explained, "We do know the manager and have spoken to her about our concerns. She was very respectful and did listen and said she would address our concerns with staff. I feel sure she has but they are not always regular staff on here so the messages don't always get through to them."

We looked at how the provider managed complaints made about the service. We saw these were investigated and responded to in a timely way. The manager had put into place a system of learning from complaints to improve the quality of care provided.

Inadequate

Our findings

In the three years prior to the current manager being appointed, the service had four different managers. The provider's quality checking arrangements had not been consistently robust and effective in making continued improvements and sustaining these during the series of changes in management at the home. Whilst procedures were in place to check the quality of the service provided, actions identified from the checks had not been prioritised in all aspects of people's care. For example, the staffing arrangements did not consistently support people's individual needs and provide assurance that risks to people's safety were effectively reduced.

Over the two days of this inspection visit, we found serious concerns about the availability of staff to offer safe care and support. Whilst the manager and regional director acknowledged this, and responded straight away and increased staffing levels on one unit during the inspection, the manager had not actioned this prior to our visit and we were not assured this would be sustained. We saw regular audits were completed by the provider and concerns identified with a plan to make improvements; however, at the time of this inspection, not all the identified concerns had been completed or sustained and people were not provided with consistent quality care. We saw a review of staffing levels was in the plan. However, this had proved to be ineffective because we found staffing levels were still not sufficient to meet people's needs.

Some senior staff expressed frustration they had raised concerns regarding staffing levels and the deployment of staff, but they had not been listened to. One staff member told us, "I came into this role thinking I could make a difference, but all my concerns have been ignored." We saw documentary evidence of where senior staff had raised concerns, but these had not been resolved.

Some staff felt the failure of managers to listen to their concerns had adversely affected staff morale. They told us they enjoyed their role, but not the pressures of not having enough staff. Comments included: "The staff work their socks off because we haven't enough staff" and, "To be working like this, I'm not happy." One member of staff on the second day of our visit said, "If we could have these staff levels every day it would improve staff morale and be better for everybody." Another said, "I'm sad a CQC inspection has to happen so that staffing is improved."

We found there was a culture of staff focussing on tasks instead of people which led to a delay in responding to people's needs and this impacted on their well-being. For example, we saw instances when people called out for support, but staff were unable to attend to them because they were dealing with other tasks. Staff on these units confirmed they were frequently frustrated because they did not have sufficient time to provide

quality care for people.

The deployment and management of staff did not always support the provision of high quality care. For example, the deployment of domestic staff on one unit meant that some bedrooms were not cleaned until late afternoon. There was an unpleasant odour on the unit on both days of our inspection visit. A relative of a person on another unit told us, "The rooms are cleaned in the same order along the corridor. Ours is the last room and the cleaner comments that she is worn out by the time she gets to the end, so usually the room only gets a quick clean. I wonder why they don't rotate where they start so that all the rooms get done properly, but it never changes."

The provider's audit system required improvement because they had not identified where they were in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, the provider's checks had not identified that some risk management plans were not in place to help staff minimise risks to people's physical and mental wellbeing. Checks of medicines had not identified the issues we found in respect of the safe management of medicines throughout the home.

Infection control checks were not robust enough. The toilet on one unit was dirty. The toilet lid was missing, there was no holder for the toilet brush and the pedal on the bin had broken so people had to use their hands to raise it. All these issues could increase the risks of infection spreading.

Learning was not always taken from safety incidents and concerns. For example, on 11 July 2017 a safeguarding concern was raised that fluid charts did not evidence that people were being given enough to maintain their hydration levels. When we visited we found staff were still not completing fluid charts accurately.

During our inspection visit we found people's experiences of care depended on which unit they lived on. We found that whilst some people's experiences were positive, other people experienced a level of care that fell below recognised standards and did not promote their health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Governance.

We could not be assured the provider understood the responsibilities of their registration with us. The provider had failed to notify us of some incidents of alleged abuse as required under our registration Regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The new manager had been in post for three months at the time of our inspection visit, but had worked for the provider for two years and was familiar with their policies and procedures. She was completing the process of registering with us. The manager told us she was aware there were areas which needed improvement to the quality of the care provided and was open about the challenges they faced at Parklands Court. They were keen to develop a strong senior team to drive improvement and take specific responsibility for various areas within the home. For example, the deputy manager's responsibilities focused on non-clinical elements such as training and management of safeguarding incidents. A new night manager had been appointed to ensure the home ran effectively at night. The manager told us this appointment had already had positive results with better provision for providing snacks and meals for those people who wanted to eat during the night.

Some people told us the service was well-led and they received the support they needed. Comments were, "[Unit manager] is very good and always comes around the rooms to check we are okay", "Anything I ask, [unit manager] will try to sort out" and, "[Unit manager] always makes an effort to look after me and make

sure I am happy". However, the positive comments were focussed on managers at unit level rather than the overall management of the home. This was confirmed by relatives who showed a more mixed response. One relative told us, "No management, they are never here. The staff are very good, but they are not managed." Another said, "Management do not address issues. Twice I have tried to contact the home manager and been told they would come back to me. They haven't." A further relative told us, "I think the unit is excellent, the unit manager is very approachable and always happy to help."

The manager told us in order to sustain improvements they needed to have a better understanding of people's needs, both individually and living as a group. For example, on one unit they had identified it was difficult for staff to balance the needs of a very mobile group who liked to explore their surroundings with the needs of people who were cared for in bed. The manager was meeting with the local authority and a specialist dementia nurse to explore ways of managing the differing needs of the people on the unit, including adaptation of the layout. They explained, "We have to adapt, not the residents." This was a positive example of multi-agency working to reduce risks.

The manager recognised that staff morale needed improving. They explained, "I can't do it myself, we need staff to invest in a journey together." They told us staff needed more training and development to give them the confidence and competency to carry out their roles safely and effectively. The manager wanted to improve communication in the home to promote fairness and transparency both within and between units. They had introduced a system to recognise and reward staff who had 'gone the extra mile'. For example, one member of staff had gone to a wedding with a person who needed support to be able to do this, and had been recognised for doing so.

Staff were optimistic about the new manager and the changes in managerial oversight of the home. Comments included: "We have seen a lot more of the home manager. I have confidence they will try to improve things and they do listen" and, "Leadership had not been stable and this has had a negative effect, but I think things are on the up now."

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had failed to notify us of some incidents of alleged abuse as required under our registration Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People's privacy and dignity was not consistently promoted throughout the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure risks to the health and safety of people on Clarendon Unit had been fully assessed and they had failed to take action to mitigate some risks. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

Treatment of disease, disorder or injury	Procedures and processes to keep people safe on Clarendon Unit were not always followed or effectively implemented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People on Clarendon, Harrison, Collins and Elmore Units did not always have enough to eat and drink to meet their nutrition and hydration needs and receive the support they needed to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively to ensure people were on all units consistently provided with a good quality service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The deployment and management of staff did not ensure there were enough staff to ensure that people using the service were kept safe at all times.