

Eagle Care Homes Limited

Eagle Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement



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?

Requires Improvement



Overall summary

Eagle Care Home is registered to provide accommodation for up to 33 older people some living with dementia. There were 31 people living at the home on the date of inspection.

Bedroom accommodation is located over two floors of the building and there is a passenger lift available to assist people with mobility problems. Communal areas consist of three lounges and a dining room.

We inspected Eagle Care Home on 27 February 2015 and the visit was unannounced. Our last inspection took

place in July 2014 and at that time we found the service was meeting the regulations we looked. However, we did bring to the attention of the registered manager some areas of service delivery which could be improved.

The home has a registered manager. 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.

Summary of findings

We saw arrangements were in place that made sure people's health needs were met. For example, people had access to the full range of NHS services. This included GPs, hospital consultants, community health nurses, opticians, chiropodists and dentists.

However, although medication policies and procedures were in place we found they were not always followed which potentially placed people at risk of unsafe care.

Staff recruitment and selection procedures were robust which helped to ensure people were cared for by staff suitable to work in the caring profession. In addition, all the staff we spoke with were aware of signs and symptoms which may indicate people were possibly being abused and the action they needed to take.

People's care plans and risk assessments were person centred and the staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. Care plans and risk assessments were reviewed on a regular basis to make sure they provided accurate and up to date information and were fit for purpose.

Staff received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards and were able to demonstrate a general understanding of when best interest decisions needed to be made to safeguard people.

We saw staff were kind and caring toward people in their care. People told us they were happy living at Eagle Care Home and were complimentary about the staff. However the needs of some people were not consistently being met and we saw little opportunity for people to engage in meaningful activities. The staff we spoke with told us this was because staffing levels did not always allow them time to do so.

There was a complaints procedure available which enabled people to raise any concerns or complaints about the care or treatment they received. However, we found in one instance the registered manager had not dealt with a complaint correctly.

We found the quality assurance monitoring systems in place were not robust or implemented consistently and therefore we could not be sure the service was managed effectively and in people's best interest.

We found four breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force on 1 April 2015. They replaced the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medication policies and procedures were in place. However, these were not always followed which put people's health and wellbeing at risk.

The staff recruitment and selection procedure was robust and newly appointed staff were not allowed to work until all relevant checks had been completed and references received. However, we found the staffing levels in place were not adequate to meet people's needs.

The staff we spoke with knew how to recognise and respond to allegation of possible abuse correctly and were aware of the organisation's whistleblowing policy.

Inadequate



Is the service effective?

The service was not always effective.

People who were able told us the way their care, treatment and support was delivered was effective and they received appropriate health care support. We saw documentary evidence which demonstrated that people were referred to relevant healthcare professionals if appropriate and staff always followed their advice and guidance.

However, we found the mealtime experience for people who used the service was very poor and some people did not receive the help and support they needed in a timely manner.

We found the location was meeting the requirements of the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own.

Requires Improvement



Is the service caring?

The service was not always caring.

We saw staff interacted with people in a kind and caring manner and people appeared at ease and relaxed in their company.

However the needs of some people were not consistently being met. The staff we spoke with told us this was because staffing levels did not always allow them to deliver care and support in line with people's needs.

Requires Improvement



Is the service responsive?

The service was not always responsive.

Requires Improvement



Summary of findings

We saw care plans were person centred and specific for the individual. We saw that people's care plan and risk assessments were reviewed regularly and whenever there were significant changes in their physical or mental health. However, we found people did not always receive care and support in a timely manner.

People who used the service and their relatives told us they knew how to make a complaint if they were unhappy. However, we found in one instance the complaints procedure had not been followed and the complainant had not received a written response to the concerns they had raised.

Is the service well-led?

The service was not well-led.

There was a quality assurance monitoring system in place designed to continually monitor and identify shortfalls in the service and any non-compliance with current regulations. However, we found action some of the shortfalls highlighted in the body of the report had not been identified through the quality assurance process.

In addition, we found some areas for improvement highlighted in the last inspection report particularly about inadequate staffing levels at peak periods of the day including mealtimes had still not been addressed by the registered manager or provider.

Requires Improvement



Eagle 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 was unannounced and carried out on 27 February 2015 by two inspectors and an Expert by Experience in the care of the elderly. 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 home. This included information from the provider, notifications and speaking with the local authority safeguarding team and commissioning service. Before our inspections we usually ask the provider to send

us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask the provider to complete a PIR on this occasion.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing care and support being delivered. We looked at four people's care records, medicines administration records (MAR) and other records which related to the management of the service such as training records, staff recruitment records and policies and procedures.

We spoke with twelve people who used the service, six care staff, the cook, the registered manager, the area manager and two visiting healthcare professionals. We also looked around the building including bedroom accommodation and communal areas and spoke with five relatives about the care and facilities provided.

Is the service safe?

Our findings

The registered manager told us sufficient staff were employed for operational purposes although three members of staff had recently left the service to take up posts outside the caring profession, therefore recruitment was on-going to appoint their replacements. They told us staffing levels were based on people's needs and were reviewed on a weekly basis.

We looked at the weekly staffing dependency tool for the week of inspection and found the registered manager had only identified two people who used the service who required two members of staff to assist them. This was because they used a hoist or other mobility aid. However, when we spoke with staff it was apparent that that the actual number of people who required assistance from two members of staff on a regular basis was seven. This meant that the staffing levels in place were not appropriate to meet people's needs.

This was clearly evident at both the lunchtime and evening meal where we observed only four staff were available to support 27 people, four of whom required full support to eat their meal. We saw the team leader administered medicines throughout the mealtimes with people being given tablets, inhalers and having eye drops instilled as they ate. The team leader was seen on a number of occasions shouting from one end of the room to the other to enquire if people needed analgesia. They told us the pressure of work dissuaded them from walking down the dining room to enquire discretely as to people's needs.

In addition, we found it was the responsibility of the care staff to wash up after meals as the service did not employ a kitchen assistant. On the day of inspection we found the team leader washing up in the kitchen following the lunchtime meal meaning they were unable to perform their main role of providing the staff team with leadership and direction.

We found that the registered person had not protected people against the risk of not having sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included ensuring a Disclosure and Barring Service (DBS) check and at least two written references were obtained before staff started work. Staff disciplinary procedures were in place and the registered manager gave examples of how the disciplinary process had been followed where poor working practice had been identified.

We saw medicines were administered to people by appropriately trained care staff yet our observations showed their practice fell short of an acceptable standard. We were told by the registered manager that no one who used the service had been found to have the mental capacity to self-medicate oral medication but one person self-administered a prescribed cream.

We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines. However, our inspection revealed there to be some shortfalls in the management of medicines.

During the morning we observed a team leader administering medicines. We saw 'as required' medicines were administered without a written protocol. On six occasions we saw the team leader recorded analgesia was refused yet on none of these occasions did we see the staff member ask the person if they needed pain relief. When this happened again we asked the team leader to explain the recording. This resulted in them going back to ask the person if they had pain to which they replied, "Yes." In the preceding 11 days this person's Medicines Administration Record (MAR) showed they had refused PRN analgesia four times each day. Our observation showed the person was not routinely being asked if they had pain which meant they may not have had their medication as prescribed.

We carried out an audit to account for medicines dispensed from named boxes. We randomly chose six medicines and on four occasions we found discrepancies. We looked at the medicines for one person who had been prescribed a medicine of two different strengths. An audit of the remaining stock of both strengths of the medicine could not be reconciled with the records.

We also found the medicines for one person had not been recorded on their MAR. This meant staff had administered

Is the service safe?

the medication for ten days without realising it was not recorded on the MAR. This clearly demonstrated to us that staff were not always following correct procedures when administering medicines which might put people at risk.

We found that the registered person had not protected people against the risk of not receiving their medication as prescribed. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with demonstrated a good understanding of safeguarding adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle

blowing policy and felt able to raise any concerns with the manager knowing that they would be taken seriously. The provider's policy on safeguarding included information on the staff's roles and responsibilities, referrals, identification of abuse, prevention of abuse, types of abuse and confidentiality.

We completed a tour of the premises and inspected a number of bedrooms as well as bathrooms, shower rooms and communal living spaces and no concerns were raised. We saw fire-fighting equipment was available, emergency lighting was in place and all fire escapes were kept clear of obstructions. We found all floor coverings were appropriate to the environment in which they were used and were of a good quality and properly fitted ensuring no trip hazards existed.

We also reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date.

Is the service effective?

Our findings

We saw nutritional risk assessments were routinely carried out and people's weight was monitored on a monthly basis. We saw ten people were on food charts so that staff could monitor their dietary intake. However, it was apparent when talking to staff that they usually filled in the food charts at the end of their shift which increased the risk of mistakes being made. This was discussed with the registered manager who confirmed that this matter would be addressed immediately.

We spoke with the cook and it was apparent they had a good understanding of people's dietary needs. The food prepared looked appetising and was well presented.

We observed both the lunchtime and evening meals. At lunchtime there were long delays between courses and insufficient staff to assist or prompt people to eat their meals. We saw one person was seated in the dining room at 12:30pm but did not receive their starter until after 13:00 and they were still eating their main course at 14:00. The mealtime was very disorganised with staff coming into the dining room to assist people and then being called away to carry out other duties.

At tea time we saw one member of staff assisting four people, seated together, to eat their meal. They stood between two people assisting both alternately, whilst the remaining two people sat with food in front of them for between 16 and 22 minutes waiting for assistance. We saw that a second member of staff prepared drinks for all the people whilst a third member of staff appeared for a while, served a few sandwiches and then disappeared.

We witnessed the member of staff who was assisting four people to eat their meals had to break off at one point to take another person to the toilet. The whole meal time experience appeared to be a task which had to be achieved by whatever means without any consideration for people need and preferences. This had also been the case when we visited the service in July 2014 and although this had been discussed with the registered manager at the time it appeared very little action had been taken to address this matter.

We found that the registered person had not protected people against the risk of not receiving the necessary support they required to eat their meals. This was in breach

of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told by the registered manager that three people using the service were subject to authorised deprivation of liberty and a further three applications had recently been made. People's care records demonstrated that all relevant documentation was securely and clearly filed. We saw on two occasions the best interest assessor had recommended conditions were attached to the authorisation. We saw bespoke care plans had been constructed to ensure the conditions would be acted upon and be subject to regular review.

We spoke with the registered manager about the use of bed-rails. Our discussion demonstrated bed-rail assessments were used to ensure people who may roll out of bed or have an anxiety about doing so would be protected from harm. The registered manager demonstrated a good understanding of how inappropriate use of bed-rails may constitute unlawful restraint.

However, immediately following lunch we observed five people waiting by the lift. Upon enquiring we were made aware the people were waiting for a member of staff who had a key to allow people access to their rooms. We spoke with the registered manager to explore how limiting access to people's rooms promoted independence and maintained people's dignity. The registered manager told us they were seeking to achieve a balance. We were told that anyone wanting to go to their rooms could ask and staff would unlock the door. We were told some people had the mental capacity and ability to have their own key and were given one on admission.

The registered manager said the problem of leaving room doors unlocked gave the opportunity from some people to wander into other people's rooms. We looked at care plans and records to look for assessments of people's ability to hold keys and to look for formal consent agreements. We found nothing to support the policy of locking people's doors and restricting free access. Whilst appreciating the registered manager's need to strike a balance between free access for people and the need for internal security the

Is the service effective?

decisions and the rationale needs to be made clearer. The registered manager confirmed they would address this matter and ensure they did not restrict people's movement within the home.

We looked at a random sample of five of the sixteen care plans which recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff and they were aware of the DNACPR decisions and that these documents must accompany people if they were being admitted to hospital.

We saw evidence in written records that staff had worked with various agencies and made sure that people accessed other services in cases of emergency, or when people's needs had changed. This had included GPs, hospital consultants, community nurses, tissue viability nurses, speech and language therapists and dentists. Care plans were clearly indexed to allow staff to easily access other health care professionals' written advice.

The registered manager told us all new staff completed induction training on employment and always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised. This was confirmed by the staff we spoke with.

The registered manager confirmed that following induction training all new staff completed a programme of mandatory training which covered topics as dementia awareness, infection control, emergency first aid and health and safety. We saw the majority of training courses made available to staff were provided by a recognised external training organisation. This meant staff were provided with a work book, watched a training video and then completed a test paper on their knowledge of the chosen subject. The test paper was then sent to be marked by the external training organisation.

The registered manager confirmed additional training specific to the needs of people who used the service was also provided. For example, we saw a tissue viability nurse had recently held a training course on pressure ulcer prevention after this had been identified as an area in which staff would benefit from receiving further training.

Is the service caring?

Our findings

We found people's needs were assessed and their care and treatment was planned and delivered in line with their individual care plan.

Throughout the inspection visit we saw that staff treated people with respect and approached them in a way which showed they knew the person well and knew how best to assist them. People were very comfortable, well dressed and clean which demonstrated staff took time to assist people with their personal care needs. One person receiving respite care told us, "The staff here are wonderful; everything I need is here and I am in no rush to leave." Another person told us "The staff are very, very good, they'll help you all they can, and I can't speak highly enough of them."

We looked at three people's care plans and found they contained information about people's past and current lives, their family and friends and their interests and hobbies. We saw specific information about people's dietary needs, their likes and dislikes, their lifestyle and the social and leisure activities they enjoyed participating in. This showed that people were able to express their views and were involved in making decisions about their care and treatment.

The staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. They were also able to explain how they helped to maintain people's dignity, privacy and independence. For example by addressing them by their preferred name and always asking for their consent when they offered support or help with personal care.

The registered manager told us that people's needs were assessed prior to admission to make sure they had the

facilities and skills within the staff team to care for them appropriately. A further assessment at the point of admission was also completed which included a detailed life history completed by the person or their relatives. The history was written in the first person and gave staff a clear understanding of people's past which was utilised in reminiscence therapy sessions. The approach to care planning meant that people were actively encouraged to participate in planning their care and the staff had up-to-date guidance on how to support each individual.

However, whilst the care plans we looked at gave staff clear guidance and direction we observed that care was not consistently delivered in a timely manner. We observed on a number of occasions people having to wait for needs to be met or staff having to break off assisting one person to meet the more urgent needs of others. This was particularly obvious from early to mid-morning and during the early evening when meals were being served.

One relative told us "Although the staff do their best I have observed that people sometimes do have to wait quite a long time before they are attended to and this can be a real problem if they need to go to the toilet." Another relative told us "On several occasions I have had to go looking for staff because someone has been shouting out for assistance and there has been no staff around to help them. It is much more noticeable during the evening when staff are assisting people to get ready for bed. I am always afraid someone might fall."

We were told that one person had an advocate. Whilst the person was not able to speak with us about the advocacy it was clear that the appointment was relevant. The person had no-one who could be appropriately consulted when making a decision and they did not have the capacity to make that decision alone.

Is the service responsive?

Our findings

The care plans we looked at were person-centred and documented people's wishes in relation to how they wanted their care and support to be delivered. The care plans evidenced how people liked to spend their time and how they liked to be supported. The people we spoke with and/or their relatives told us they were involved in the care planning process and were kept informed of any proposed changes to their care plan.

We saw care plans were developed from the initial pre-admission assessment. The profile derived from the pre-admission assessment covered such issues as mobility, continence, eyesight, hearing, memory, feeding ability and a falls history. The pre-admission assessment also recorded primary and secondary diagnoses and a list of all current prescribed medicines. The care plan focussed on the need to maintain a safe environment and promote personal independence and dignity.

All the care plans we looked at had a degree of similarity to allow staff to develop a common understanding of all people's needs. All care plans were laid out in the same order and covered crucial elements of care such as falls assessments and people's nutritional needs. However, all care plans had large elements of individual care planning. We saw that whilst all people had a general assessment of skin integrity each care plan identified where a person's tissue viability may be more prone to damage and how staff should address this. This demonstrated the provider was ensuring areas of common risk were tailored to individual people's needs.

We saw where people were at risk of falls an assessment was carried out. We saw where mitigating measures to prevent falls had been found to be ineffective the provider had sought more specialist advice from occupational therapists and physiotherapists.

We saw dependency scores had been given to people's needs to be helped with personal hygiene, mobility or eating. However on a number of occasions we saw dependency records demonstrated one carer was required to give assistance yet we witnessed two staff doing so. This demonstrated some care plans and dependency ratings needed to be reviewed.

We were told by the registered manager that the service did not employ an activities coordinator therefore it was the

responsibility of the care staff team to provide people with a range of in house activities. However, although there was an activities programme in place we did not see evidence of any meaningful activities taking place and staff told us their ability to fulfil this role was dependent on staffing levels.

The people we spoke with had differing views on the levels of activities made available to them. One person said they personally thought there was enough activities they told there was sometimes a quiz in the afternoon and they played dominoes two or three times a week. However, another person told us there was little to do but watch day time television and at times was bored.

We looked at the results of a recent quality assurance survey and found four people had commented on the lack of appropriate activities. One person made the following comment "Sometimes the staff are too busy to for activities but the TV is always on." This was discussed with both the registered manager and area manager who acknowledged more could be done to provide people with a stimulating environment.

The relatives we spoke with told us there was no restriction on visiting and they were always made to feel welcome. One person said "I live quite near the home so I visit at different times of the day. The staff always appear happy to see me and if they have time I am offered a drink of tea. I have no concerns at all about the service provided."

We looked at the complaints policy which was available to people who used the service, visitors and staff. The policy detailed how a complaint would be recorded, investigated and responded to and who they could contact if they felt their complaint had not been dealt with appropriately. The manager also told us they operated an open door policy and people who used the service, visitors and staff were aware they could contact them at any time if they had a problem.

However, when we looked at the complaints register we found that one of the three complaints received since the last inspection had not been dealt with correctly by the registered manager. This had resulted in the complainant not receiving a formal written response to the complaint even though the registered manager had investigated the

Is the service responsive?

concerns they had raised. This was discussed with the registered manager who acknowledged their mistake and confirmed that all complaints would be dealt with appropriately in the future.

The people we spoke with told us they were aware of the complaints procedures and knew how to make a

complaint. One person told us, "I would tell the person in charge if I had any concerns and I am sure they would sort it out." Another person told us, "I have never made a complaint but I have spoken with staff about one or two things I was unhappy about and they sorted them out for me."

Is the service well-led?

Our findings

We saw there was a quality assurance monitoring system in place that continually monitored and identified shortfalls in service provision.

The registered manager told us they audited people's care plans and risk assessments, the complaints register and the accident and incident log on a regular basis so that action could be taken quickly to address any areas of concern. We saw the registered manager also audited the staff files and checked the staff training matrix on a routine basis to make sure they provided accurate and up to date information.

However, although we found some of the shortfalls in the service identified in the body of this report had already been identified through the quality assurance monitoring systems, action had not always been taken to address matters. This raised concerns about the effectiveness of the quality assurance monitoring process.

In addition, we found the areas for improvement highlighted at the last inspection in July 2014 relating to the management of complaints, activities and staffing issues around peak periods of the day including mealtimes had still not been addressed by the registered manager or provider.

We found that the registered person had not protected people against the risk of not operating an effective quality assurance monitoring system. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the area manager visited the service on at least a monthly basis and carried out a quality assurance audit. We looked at the past audits and saw they highlighted both good practice and any shortfalls in the service which needed to be addressed either by the registered manager or other individuals within the organisation.

We saw the area manager had also recently introduced a self-assessment form for all services with the organisation to complete which was designed to highlight where the service was meeting current regulation and any shortfalls in service provision. The area manager confirmed this was still work in progress but would assist the organisation to formulate an action plan and improve service delivery.

The registered manager told us as part of the quality assurance monitoring process the service sent out annual survey questionnaires to people who used the service and their relatives to seek their views and opinions of the care and support they received. The registered manager confirmed the information provided was collated and an action plan formulated to address any concerns or suggestions made.

We looked at a number of recently completed questionnaires and found that while most of the comments received were positive there were areas including the lack of social activities where people felt improvements to the service could be made.

The relatives we spoke with told us they had confidence in the registered provider and staff team and were generally pleased with the standard of care and support they received. Comments included, "I have always found the manager to be approachable and because they work within the home on a daily basis they are always available if I need to discuss anything with them" and "I have no doubt the manager is trying to provide a good service but they really do need more staff."

We saw regular meetings were held with people who used the service. We looked at the minutes of the last meeting which was attended by nine people and saw the topics discussed included activities and entertainment, meals, the environment and general health and safety issues.

In addition, we saw periodic staff meetings were held to ensure all staff were kept up to date with any changes in policies and procedures which might affect the management of the service or the care and treatment people received.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The registered person did not have suitable arrangements in place to ensure people who used the service received their medicines as prescribed.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person did not have suitable arrangements in place to regularly assess and monitor the quality of the services provided.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The registered person did not have suitable arrangements in place to ensure people received the necessary support they required to eat their meals.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered person did not have sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty to meet people's needs.