Lawford House Residential Care Home

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Inspection report

Lawford House
Walford Road
Ross On Wye
Herefordshire
HR9 5PQ

Tel: 01989566811

Date of inspection visit:
12 April 2016
23 May 2016

Date of publication:
21 June 2016

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Lawford House is located in Ross-on-Wye. The service provides personal care for up to 15 older people. On the day of our inspection, there were 11 people living in the home.

The inspection took place on 12 April 2016 and on 23 May 2016 and was unannounced.

There was no registered manager at this service, and there had been no registered manager in post since March 2015. The acting manager had resigned from their post shortly before our inspection and was providing managerial cover only until a new manager was appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

Not all individual risks were known by staff, the acting manager and provider and consequently, were not always managed, which placed people at risk of harm and abuse. There was no mechanism in place for determining adequate staffing levels, or deployment of staff.

People's changing health needs were not always responded to. Staff did not always refer to other healthcare professionals when necessary.

Not all staff had been given an induction or training when they started work at the home. Not all staff had undergone pre-employment checks to ensure they were suitable to work with people.

People were not always treated with dignity and respect and did not always have their privacy maintained.

The provider had not followed the principles of the Mental Capacity Act 2005. People's liberty had been deprived without the necessary authorisation from the local authority.

The service lacked managerial stability. Staff were unsure what was expected of them and what the values of the service were. The provider did not have a whistleblowing policy in place, and staff did not know how to make a whistle blowing report. There were no quality checks or audits carried out by the provider, no mechanism for the provider to monitor the quality of care people received, or to involve people in how the service should be developed.

People who used the service received their medicines safely. People had choices in how their care was provided to them, and their preferences were known by staff and acted on accordingly.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review; if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

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 is not safe.

People's individual risks were not always assessed, which meant that staff did not know how to support people safely.

Not all accidents or incidents were recorded, and concerns regarding abuse or harm had not been reported to the local authority or acted upon by management or the provider.

There was no method of determining adequate staffing levels or suitable deployment of staff. Not all staff had undergone pre-employment checks before working with people.

People received their medicines safely and as prescribed by their GP.

Is the service effective?

Requires Improvement

The service was not always effective. Staff were not clear of their role in meeting people's needs. People's liberty was restricted without the necessary authorisation. People were supported with their nutrition needs.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always treated with dignity and respect. Staff's interactions with people were not always caring. People had choices in how their care was provided.

Is the service responsive?

Inadequate

The service was not always responsive. People's changing health and care needs were not always responded to. People were not consulted on what activities they wanted to do, and activities provided were not individualised. People were unsure who to complain to if the need arose.

Is the service well-led?

Inadequate

The service was not well-led. There was no registered manager in post and a high turn-over of managers, with four managers

leaving in the last 13 months. Staff were unsure of their roles and what was expected of them. Staff felt they could not approach the provider at any time, or that the provider was involved in the service. There was no system in place to monitor and review the quality of the service, or to involve people, relatives and health professionals in the delivery of the service.

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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.

We made an unannounced inspection on 12 April 2016; the inspection team consisted of two inspectors. As a result of additional information we received after this inspection, we made a further unannounced inspection on 23 May; the inspection team consisted of one inspector.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service. This information helped us to focus the inspection.
Before the inspection, the provider also completed 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 asked the local authority if they had any information to share with us about the care provided by the service.

We used the Short Observational Framework for Inspection (SOFI) because some people were unable to communicate with us verbally so we used different ways to communicate with people. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We spoke with seven people who use the service, and one relative. We spoke with the acting manager, the

provider, the cook, and five staff. We looked at four care records, the medication administration records, and the incident and accident records.

Inadequate

Is the service safe?

Our findings

We reviewed the way in which accidents and incidents were recorded in the home and saw that these were recorded and then reviewed by the acting manager. However, due to the managerial instability at the home, not all incidents and associated risks were known by the acting manager or the provider. For example, the local authority informed us of a safeguarding concern which occurred after the first day of our inspection. We spoke with the provider, who told us they had recently discovered staff had raised concerns about similar incidents with the previous manager, but no action had been taken. Consequently, the risk to people had not been communicated to the wider staff team, the local authority, the CQC or to the provider. As a result, there were people in the home who were not protected from the risk of harm or abuse.

We reviewed how individuals' risks were recorded, monitored and reviewed. We spoke with staff, the acting manager and provider about a person with complex health needs. The person met with the acting manager before moving into the home and it was identified that they had safety needs arising from their health condition, including being at high risk of falls. However, no risk assessment was in place regarding how to support the person and keep them, or other people in the home, safe. Staff were able to explain to us how the person's health affected their behaviour and how to tell when the person was unwell and in need of support, but were unclear as to how the person should be supported during a period of illness. We spoke with the provider, who was not able to explain to us how staff would be able to keep the person safe. We brought this to the attention of the acting manager, who contacted a health professional involved in the person's care to seek advice on how to support the person. The provider said they would discuss the matter with staff and ensure they were aware of the person's safety needs and ensure a risk assessment was put in place.

We looked at the way staffing levels were determined. Although people told us they felt there were enough staff to meet their needs and keep them safe, there was no method by which the acting manager and provider could assess individuals' needs and how many staff were needed on duty to keep people safe. The local authority told us they had raised this with the provider previously and were waiting for them to assess current staffing levels in conjunction with people's needs. Without the local authority's involvement, neither the provider nor the acting manager had identified the need to assess staffing levels or how staff should be deployed.

Staff told us they had recently started to have training in areas such as medication and moving and handling following a monitoring visit from the local authority, where a lack of staff training and induction was identified. Although action had been taken by the provider to arrange training and staff inductions as a result of the local authority's concerns, the acting manager and provider had not identified staff training needs prior to this. Staff told us that they had not received training regarding keeping people safe and how and when to refer concerns to the local authority. We discussed this with the provider and acting manager and were told this training had been arranged as a priority. However, neither the provider or the acting manager had taken steps prior to input from the local authority to ensure that staff were trained in keeping people safe, which put people at risk of unsafe care.

The local authority had raised concerns that the provider had not carried out pre-employment checks on all staff before they worked at the home, including reference checks and checks with the Disclosure and Barring Service ("DBS").These checks are to ensure that people living at home are not put at risk of harm by the provider's recruitment process. We spoke with the acting manager and they were unsure as to whether staff had gone through the necessary checks, so they reviewed every staff member's file and showed us the DBS checks had now been carried out. Although the checks had now been carried out, the failure of the provider to carry out checks on all staff before they worked with people meant that unsuitable staff could have been working with people in the home, and placed them at risk of harm or abuse.

We checked whether routine safety checks were carried out on aids and equipment and saw that checks were carried out every six months, with staff reporting any concerns in between these checks. This meant that people were not put at risk from the aids and equipment used.

People told us they received their medicines regularly. We saw that people received their medicines safely and as prescribed by their GP. Medicines were stored appropriately and records of medicines given were maintained. There was a system in place for staff to check medicines and medicine records and ensure these had been given correctly. In the event of a medicine error, staff knew what action to take and how to record this.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us that when they started their roles, they had not been given any induction or training. One staff member told us, "I had worked here for a year before I was given any training". Another staff member told us, "I had no training. I was just told, off you go". Another staff member told us staff needed end of life care training as they did not feel confident in this area and also felt that it would help staff deal with the emotional impact of when a person passed away. Following involvement from the local authority, we saw that all staff had been given a training programme and that they had recently completed training on medicines and manual handling. Staff told us this training made them more confident in their roles and helped them to support people more effectively. We spoke with the provider who recognised that staff had not been given adequate training, inductions and support and that told us that staff training was a priority, with further training scheduled for all staff.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

We reviewed three DoLS applications in people's care files. We saw that in all three files, the DoLS authorisation dates had expired six months' ago and that new applications had not been made. This meant that staff were unlawfully restricting people's liberty since the DoLS expiration dates. We brought this to the attention of the acting manager, who contacted the DoLS team that day to arrange the outstanding reviews. The acting manager told us that due to the amount of managerial changes, the DoLS reviews had not been attended to. We brought this to the attention of the provider and informed them that regardless of managerial changes, the legislation must be followed.

Staff we spoke with did not have an understanding of the DoLS process and why they might need to be put in place. One member of staff told us that a DoLS authorisation meant that a person had the freedom to do what they wanted. Another staff member was not able to explain to us what action they would take, or what would need to be considered by staff, if a person told staff that they were leaving, opened the front door and left the home. We asked the acting manager how many DoLS applications had been made, and why. The acting manager did not have a system for monitoring the applications and review dates, so this information was not readily available to them. After the acting manager checked this information, they told us that every person had a DoLS application in place due to the fact they lived in a care home. This was not in accordance with the MCA. Staff told us they did not feel confident in their knowledge about DoLS and that they needed more training in this area. We discussed this with the acting manager and the provider who told

us that additional training would be arranged.

Staff and the acting manager were not able to explain to us the principles of the MCA in relation to gaining consent, people's capacity to make decisions and acting in a person's best interests. However, although staff did not have knowledge of the Act, we saw that they did apply its principles of choice and consent in their practice. For example, we saw that people had the right to refuse their medicines and that no covert medicines were given. One staff member told us, " You can't force things on people, they must have a choice". We also observed that staff sought people's consent when assisting them, such as asking people if they wanted any help with eating their food. Although staff could not explain to us the principles of least restrictive practice, we observed that people were not restricted by staff, nor were any restrictive aids used. We saw that consideration was given to people's capacity to make decisions. For example, we saw on one person's care plan their capacity fluctuated with their health, and that a meeting had been held with the Mental Health Team regarding acting in that person's best interests.

People told us that they enjoyed the food and drinks provided and that they were offered choices. One person told us, "I like the mashed potatoes best, a few greens". Another person told us, "They certainly don't starve you! ". Another person told us, "I like lots of cups of tea with three sugars. They know how to make it the way I like it and I'm always asking them to make me one, and they do".

We spoke with the cook who told us that they were kept informed about people's nutrition and hydration needs and any medical conditions which may affect the meals provided, such as diabetes. We saw that the cook had a system for recording people's needs, as well as their preferences regarding their meal choices. We saw that where a person did not want the meal on the menu that day, other choices were provided. We observed the lunchtime meal and saw that people had a choice of drinks and desserts, including fresh fruit.

We looked at actions staff had taken where they had identified someone as being at risk of malnutrition, or where there were concerns about someone's food intake. We saw that where concerns were identified about people's weight loss, appropriate medical attention was sought and people were monitored to ensure their food and intake was of the necessary level to prevent any further weight loss.

People told us, and we saw from their records, that they had appointments with other health professionals, including opticians, psychiatrists and district nurses. People's care records included health appointment charts so that staff could monitor appointments and record any actions required following a health appointment.

Requires Improvement

Is the service caring?

Our findings

We asked people whether they were treated with dignity and respect by staff and they were unable to give us any examples of this. We observed that people's dignity and respect was not always promoted. For example, we saw that staff did not make all reasonable efforts to ensure that discussions about people's care, treatment and support only took place where they could not be overheard. During lunch, we heard one staff member discuss one person's personal care needs in front of other people .This was not respectful of the person's privacy and placed them in an undignified situation. We spoke with staff about dignity and respect, and they told us they had not received any training or guidance on this. We discussed this with the acting manager and staff, who told us that training would be arranged regarding dignity and respect and that work would be carried out about raising staff's awareness of promoting people's dignity to ensure that all staff have an understanding of its importance.

On the second day of our inspection, we observed that one person received personal care in a communal area in front of other people. The person was not given a choice as to whether they would prefer to receive the assistance in their bedroom, which meant their privacy and dignity was not considered. There was no working lock on the door of one of the shared bathrooms, which meant that people could not have privacy when in this room. We brought this to the attention of the provider who told us that all staff were to be told in writing that people must be treated with dignity and respect; no training had been arranged for staff.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities).

We saw that although there were four staff on duty, staff time was not always utilised towards having caring and meaningful interactions with people. For example, during lunchtime, people ate in the dining room and staff ate separately. Although staff did check on people intermittently during the meal, there was little interaction during this time. People told us that staff did not eat with them. When we joined people for lunch, one person told us, "How lovely! You want to sit with us". There were also three occasions during the course of the inspection where staff members stood in the same place in one lounge area for up to 15 minutes, with no interaction with people. We raised this with the acting manager who told us that as the staffing levels had not been adjusted to reflect the current vacancies in the home, there were more staff on duty than was required and as a result, staff were not always sure how to spend any spare moments of time. The acting manager told us they would discuss this with staff and ensure that the extra staffing levels were used to spend more time with people, such as speaking with people on a one to one basis.

People told us that they felt staff were caring. One person told us,"They are very kind. It's nice here, really". Another person told us, "They are very friendly. They do look after us".

We saw that people chose what clothes they wanted to wear, rather than staff choose for them; people chose whether they wanted their hair and nails done, and chose what drinks they preferred to be given. We spoke with people who told us they had been involved in decisions about their care, and this was reflected in their care records. For example, one person told us they preferred cold to hot drinks. We saw that staff did give this person cold drinks during the course of our inspection.

We observed some caring and positive interactions between staff and people and observed that staff knew people well. For example, one person talked to us about their previous job and staff were aware of this job and how much the person enjoyed discussing it and they discussed it with them. We also saw that one person enjoyed singing and that staff joined in with them, which the person enjoyed.

We observed the staff handover in the afternoon. A handover is a brief meeting between staff at the end of one shift and the start of the next shift. We observed that one staff member told other staff that one person had told her they now wanted to be known by their middle name, not their first name. We saw that staff were respectful of this person's preference and that this information was recorded. During the handover, this person walked past the office and staff addressed them by their preferred choice of name. The person was clearly very happy to be addressed by this name.

Inadequate

Is the service responsive?

Our findings

During the course of our inspection, we observed one person who told a staff member they were experiencing pain in their leg. We saw that this leg had a dressing that had been pulled down and broken areas of skin were visible. The staff member made the person a drink, but no specific action was taken regarding the person's concern. This person was prescribed pain relief medicines which were to be given 'as required' for pain, but this was not offered. The person told us they wanted to see a GP and that, "I have told staff, but they don't listen".

We checked this person's care records and saw that they had complained of pain for the last three days, but their GP had not been contacted. We brought this to the attention of the acting manager, and the district nurse was called and visited that day, who prescribed medication for an infection in the person's leg. The acting manager accepted that had this matter not been brought to their attention, action would not have been taken as they and the staff believed that it was the responsibility of the district nurses to attend to such concerns. We were also told that the person in question often complained of pain without any immediately obvious physical cause. We discussed this incident with the provider, who also indicated that it was for the district nurses to ensure people they see at the home were given any necessary medical attention.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

People told us there were not many activities for them to take part in. One person told us, "I'm not sure what we do really. Not much". Another person told us, " We do a bit of singing, I like that. I can't think as to what else we do".

The acting manager told us that they were aware that there not enough activities for people and that staff had been encouraged to spend more time on this area. We saw that people had not been consulted on what activities they would like to take part in, and that the current options were limited. For example, we saw that a game of darts took place with people and the morning staff and that the afternoon staff also suggested a game of darts. One person said, "Darts again? We played that this morning!" We saw that the activity was then changed to bingo, and we observed six people who enjoyed this game with staff. However, people told us, and we saw that, the activities were infrequent. We observed the staff handover in the afternoon and staff discussed possible future activities, including buying a garden 'Jenga' game. People were not asked whether they would like this game to be bought, or whether they would enjoy playing it. Consideration was also not given as to whether this game would be suitable for people's needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

We saw that the acting manager and a senior staff member had recently updated and reviewed people's care plans and that consideration had been given to people's preferences, likes and dislikes, life histories and interests. For example, we saw that in one person's care plan, it had been recorded that the person liked animals. As a result of this, some staff members had brought their dogs in for this person to spend time with.

We also saw that the acting manager had sought the involvement of people's family members in the care plans where possible.

Not all people we spoke with knew how to make a complaint, or to whom their complaint or concern should be addressed. One person said, " Well, I do and I don't, if you know what I mean?" Another person told us, "I suppose I would tell the staff". We saw that there were no residents' meetings in place and there was no forum for people to voice any complaints, suggestions or concerns. We saw that the details of the former registered manager were displayed and that there was a sign saying that people, visitors, relatives and health professions could approach them with any concerns or suggestions; the details of the acting manager were not displayed and it was unclear who complaints and feedback should be raised with. We also saw that there was no complaints policy or procedure in place. We raised this with the acting manager and provider, who were aware that a system needed implementing. Although there was no complaint systems in place, the acting manager told us they had been contacted by a relative recently to make a complaint regarding the laundry system used in the home. We saw this complaint, and the steps taken by the acting manager to rectify the issue. However, whilst this relative had been able to make a complaint, there was not an accessible system in place for identifying, receiving, recording, handling and responding to complaints. This meant that potentially, not all complaints or feedback could be captured, monitored and acted upon. Additionally, as there was no manager in place, there was no one to implement a complaints procedure or to oversee complaints received.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities).

Inadequate

Is the service well-led?

Our findings

Since March 2015, the provider had employed four consecutive managers; none of the managers were registered managers. The deputy manager had recently acted as manager, but had resigned from this post the week before our inspection. The acting manager told us they had resigned as they did not feel adequately supported in the role by the provider. We discussed this with the provider, who told us that previous managers had left due to the amount of work involved in the role. We discussed with the provider how they would support the next manager with this workload, but other than visiting the home more, it was unclear how the provider intended to do this. By not having a registered manager in post since March 2015, the provider was in breach of their CQC registration requirements.

Some people were able to tell us who the acting manager was, but other people told us they were unsure. One person said, "I did know who it was, I'm not too sure now". Another person told us, "It's the lady in the office". People told us that they had not been asked for their opinions or feedback on how the home is run. For example, we saw that there were plans to re-decorate areas of the home, but we could not see any evidence of people consulted on how they would like their home to be decorated.

Staff told us that the culture of the home, and day to day practice of staff, had been affected by the management changes. One staff member told us, "It's been a nightmare, to be honest. You get used to the way one manager wants it done, then a new one comes in and wants it done a different way". Another staff member told us, " We have no supervisions, no staff meetings. We have just never settled as a proper team as there is no consistency in management". We were also told by a staff member, "How can I do my job properly if I don't know what my role is?" Another member of staff told us when asked what the values of the service were, " I haven't got a clue. I don't know what is expected of me. It's been really stressful". Staff told us, and we saw that, they did not receive any supervisions or appraisals. One staff member told us, "I'd like to know what I am doing right or wrong and how I can improve". Staff told us that due to the fact there had been four managers in the last 12 months, it had affected how they worked together as a team and how they communicated. One staff member told us, "Things get missed by us as a team. We don't always communicate very well as we don't know where we stand. We don't have a communication book anymore and that causes problems". We saw examples of this during the course of our inspection. For example, the staff on duty that day were unclear as to when someone's leg had last been dressed by the district nurse. We saw that staff had to contact other staff members to establish the position regarding the dressing and ensure that the person's dressing did not need changing that day.

Staff and the acting manager told us they saw the provider once a month and that they did not feel supported in their roles by them. During the course of our inspection, we spoke with the provider about some areas of concern and how the managerial instability was affecting the quality of care provided. They told us that a registered manager would be appointed as a matter of urgency and that they were in the process of interviewing candidates. The provider also told us they would visit the home more regularly and would discuss issues with staff and seek to resolve them.

We spoke with staff about the provider's whistleblowing procedure and what they would do if they needed

to raise an alert about practice at the home. The term whistleblowing can be defined as raising a concern about a wrong doing within an organisation. Staff were unsure of the procedure and told us they did not know what they would do. This meant that staff had no forum to raise any concerns.

We spoke with the acting manager who told us they were aware that due to having spent a lot of time in the office working on people's care plans and various administrative tasks which were outstanding, they were "Out of touch" with staff's working practices and behaviours and that there had not been an opportunity to carry out any audits or competency checks. We asked the acting manager about communication between staff members and how effective this work, and they told us, "You will have to ask them". The acting manager told us, "I have been so busy trying to get the basics right, there has been no chance to develop the service. I don't get chance to see what is going on out there". This meant that neither the provider, nor the acting manager, had oversight of staff's daily practice, or how this was affecting the quality of care provided to people.

The acting manager was aware of what actions needed to be taken and was able to show us some of their planned course of action, such as implementing a complaints system and arranging a coffee morning for relatives and friends of people living in the home to attend and give feedback on how they think the home is run. However, this had not been implemented and there was no schedule for when the action would be taken.

We saw that there were no systems in place for the acting manager and the provider to improve the quality and the safety of the service, including the quality of the experiences of people who lived there.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not supported to retain individual hobbies and interests. People were not asked how they would like to spend their time. Where activities were provided, these were limited and people were not asked what they would enjoy doing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff discussed people's personal care needs in front of others, and some people received personal care in a shared area instead of in the privacy of their own bedroom or bathroom. Not all shared bathrooms could be locked, which meant people's privacy was compromised. Staff had not received any guidance or training in how to respect and promote people's dignity, and were unaware of its importance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always referred to health professionals when they asked to be, or when they needed to be. As a result, people's health needs were not always met and they did not always receive necessary treatment.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no complaints procedure in place, and no manager in post to either implement this system, or to monitor it. People were unsure how to make a complaint, and to whom.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There had been no registered manager in place since March 2015 and over 12 months of managerial instability, with four managers being appointed during this period and all four leaving. There were no quality assurance measures in place, and no means of reviewing the quality of care people received. Staff did not receive supervisions or appraisals and were unclear of their job roles and responsibilities, and how they were performing. Staff and the acting manager were unsupported by the provider.